

CALIFORNIA HEALTH CARE FACT BOOK



Gray Davis
Governor
State of California

Grantland Johnson
Secretary
California Health and Human Services Agency

David Werdegarr, MD, MPH
Director
Office of Statewide Health Planning and Development

1999

Letter of Introduction from OSHPD Director David Werdegar, MD, MPH

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Early in the process of developing the first edition of the ***Fact Book***, the Office sought and received numerous contributions from internal staff at OSHPD and the California Health Policy and Data Advisory Commission through its Health Data and Public Information Committee. Commissioners Hugo Morris and Howard Harris, Ph.D. deserve special recognition for comments and guidance in producing the general layout for the first ***Fact Book*** in 1996. Megan Florida is recognized for technical contribution and Margaret Gerould for project oversight.

Finally, OSHPD would like to thank its Office of Health Information for Policy (OHIP) for its effort in establishing the ***Fact Book***, both in print and on the Internet. OHIP was originally funded with a grant from the Robert Wood Johnson Foundation. The Foundation recognized that the vast statistical information gathered by State agencies on health-related programs and issues is often inaccessible to policy makers or is not available in an easy-to-use format. OSHPD is addressing this problem in a number of ways--one of which is the preparation of the ***Fact Book***.

Preface

Twenty years ago, the average American thought little about health care until illness or injury compelled one to seek the services of a doctor or hospital. Once under the care of a health professional, most decisions regarding treatment and coordination of care were entrusted to experts with little or no involvement from the patient. At the end of care, most bills were paid by the patient's health insurance or other third party payer, leaving most people unaware of the actual cost of care they received.

Today, the situation is quite different. Discussions of health care are regularly found on the front page of the local paper, on prime time news and at the center of national and local political debates. Topics vary--the cost of health care, the uninsured, quality of care, managed care, illness prevention. Throughout the discussions, one theme remains the same: Californians must be active participants in decisions about health care in order to assure their needs are met (individually and as members of the larger community). In order to make intelligent decisions, an understanding of some basic facts about health care is needed. The ***California Health Care Fact Book*** was prepared by the Office of Statewide Health Planning and Development to assist in this learning process.

The ***Fact Book*** contains information collected from a number of State departments and private organizations. It provides a snapshot of California's population trends, health expenditures, health care resources, and health status indicators. **Section One** describes California's population trends in terms of ethnic origin, age, and geographic distribution, examining past and projected growth patterns. **Section Two** provides estimates of annual expenditures made for health-related services in California. It outlines basic breakdowns of health insurance coverage for all Californians, information on the State's Medi-Cal program, and a listing of the larger health service (HMO) plans in California.

Section Three provides information on California's health care providers and facilities. **Section Four** presents selected health status indicators--pregnancy-related care; cancer, heart disease, and AIDS; the most common reasons for hospitalization; and the major causes of death. This section also describes the prevalence of mental health and substance abuse problems in the State. **Section Five** identifies some issues likely to figure prominently in discussions of health care in the near future. Finally, the **Fact Book** contains two appendices to assist readers. **Appendix A** describes the data sources used for each section of the **Fact Book**. **Appendix B** provides a listing of selected health professional education resources, a list of the California Health Policy and Data Advisory Commission members and an index.

While readers will find that the publication contains considerable information on the most serious and costly health care problems in California, there is much less information about the more common aspects of health care, such as office visits to a primary care provider, routine tests used to detect illness, office surgeries, and emergency medical services. The reason is that these types of data are not routinely collected on a statewide basis. Currently, most statewide health data are collected from hospitals and other health care facilities. But, looking to the future, as more and more care is provided outside the hospital, data about outpatient care will become increasingly important to understanding health care in California.

The **Fact Book** does not offer opinions about how facts should be interpreted. As the name implies, the purpose of the **Fact Book** is to present objective information to be used by readers in making their own judgements, and to encourage the use of available data about California's health care system.

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Section One

California Population

Population Trends

Approximately 33 million people live in California, representing just over 12 percent of the entire United States population. Although the state's growth rate has slowed some since 1990 due to a general decline in birth rates, California's population is projected to increase by 30 percent, to nearly 41 million people, as it approaches the year 2010.

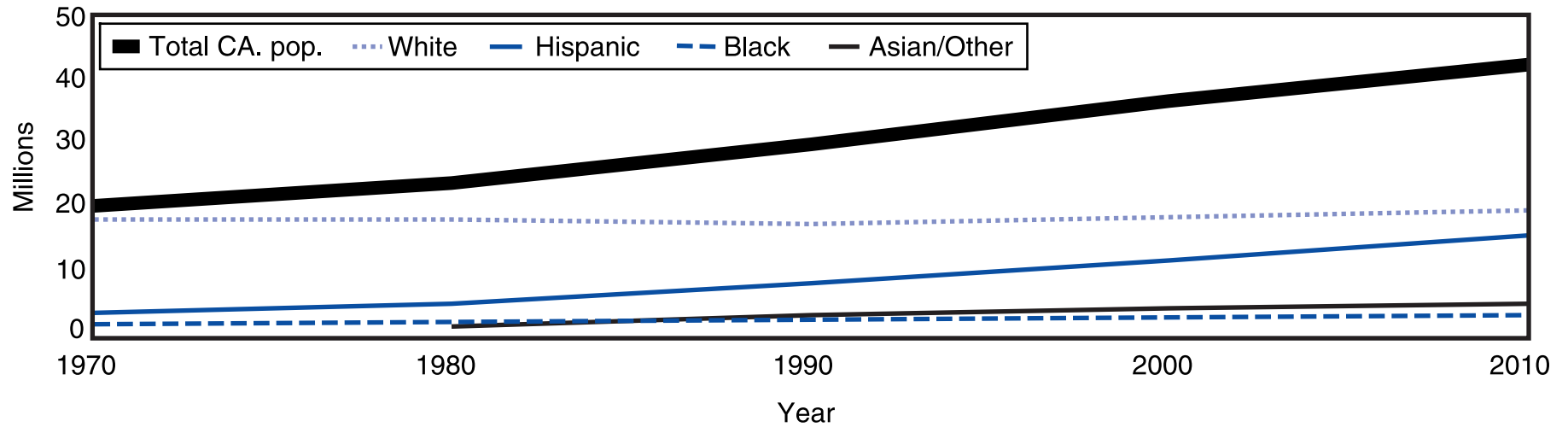
California's population is ethnically diverse. The 1996 population figures show a distribution of 52 percent White, 29 percent Hispanic, 10 percent Asian/Pacific Islander, 7 percent Black, and one percent Native American. California's Hispanic and Asian populations doubled between the 1980 and 1990 census. Higher growth rates in Hispanic and Asian populations are attributable to births, immigration, and longer life spans. The Hispanic population is predominantly Mexican-American and has the highest birth rate. Between 1980 and 1996, the proportion of Hispanic births grew from 29 to 47 percent of all births. Since 1990, Hispanic births accounted for about 60 percent of California's overall population growth. The state's Asian population had the second highest birth rate. The Asian population is heterogeneous and is represented by more than ten nationalities, e.g. Chinese, Japanese, Korean, Filipino, and many Southeast Asian groups.

The Hispanic and Asian populations will likely continue to contribute significantly to population growth in the future. As a result of expected increases in these ethnic populations, California's White population will comprise less than one-half of the State's population by the year 2010.

The state population as a whole continues to age. White females have the longest life expectancy, averaging 79.5 years. Black males have the shortest life expectancy at 64.6 years.

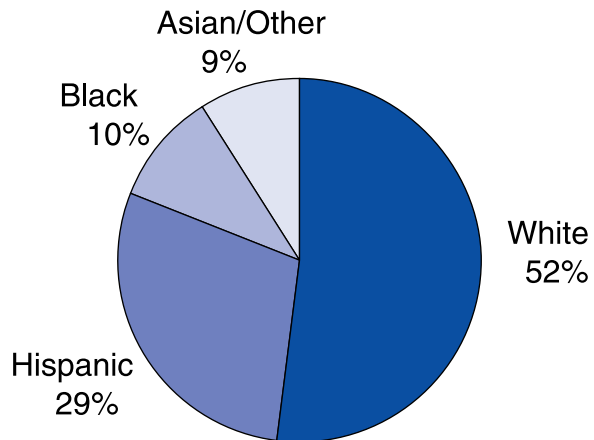
Ethnicity of Population

(1970 to 2010)

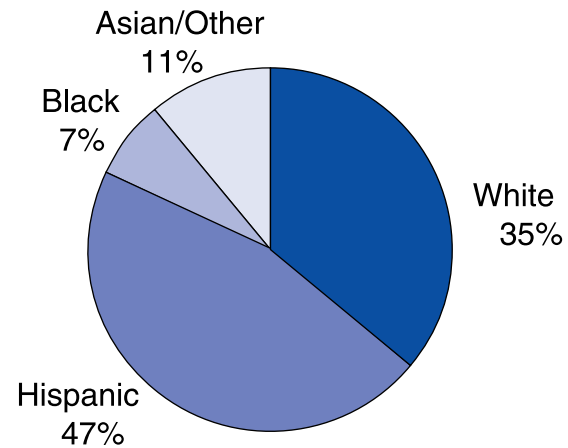


Births by Race/Ethnicity of Mother

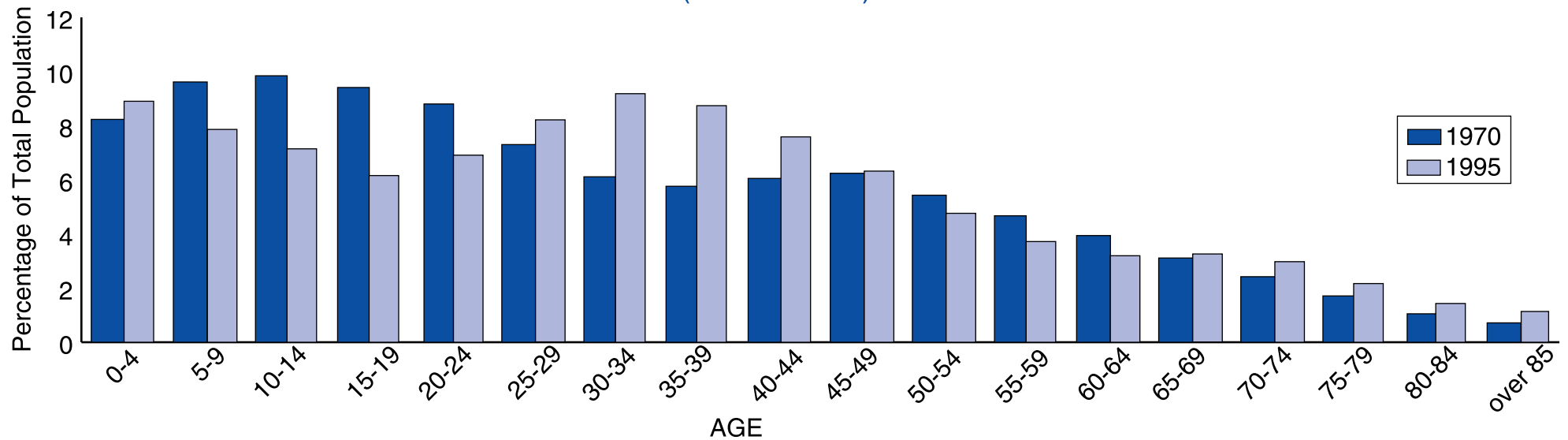
1980



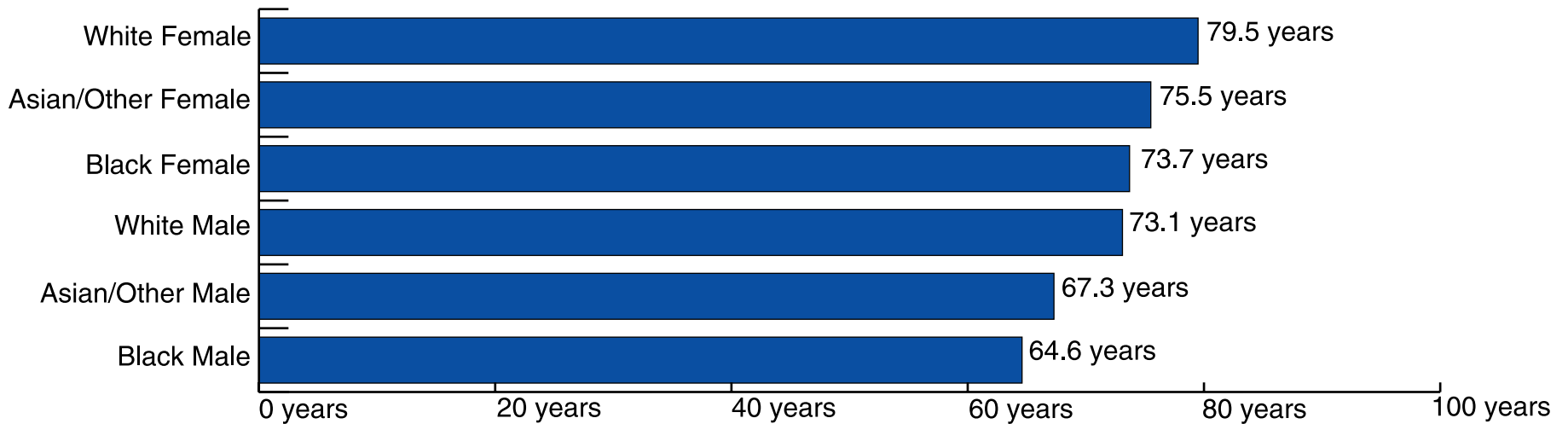
1996



Change in Age Distribution (1970 to 1995)



Average Life Expectancy at Birth (by Gender and Ethnicity, 1993)



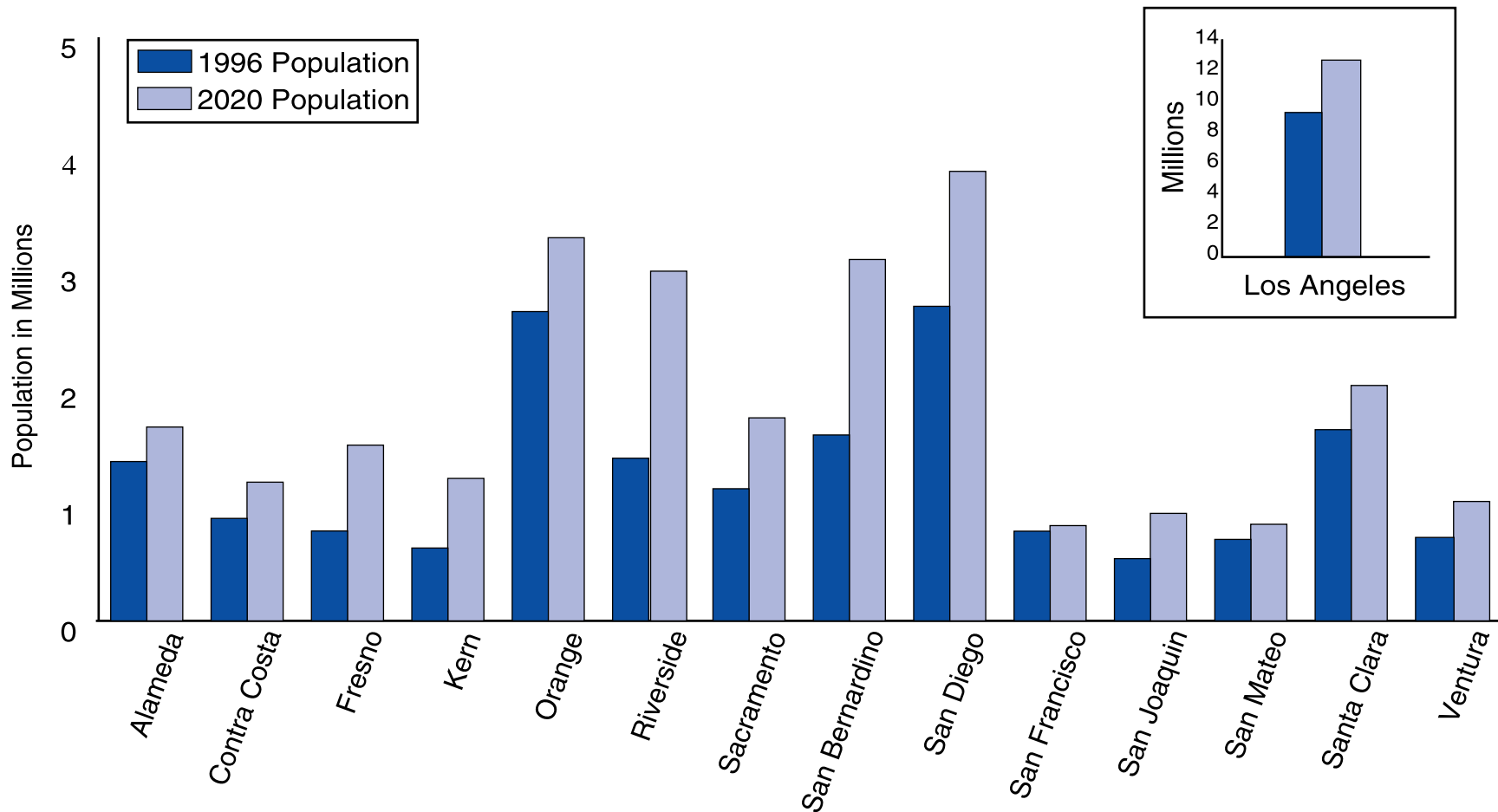
Geographic Growth Trends

Geographically, future population growth will occur both in dense urban areas along the State's coast and in its southern and central valley counties. The central valley counties of Fresno, Kern, and San Joaquin, as well as southeastern counties of Riverside and San Bernardino, will experience the most rapid population increases, with each area expected to double by the year 2020.

Rapid growth will also continue in many of the State's largest counties. By 2020, the counties of Orange, Riverside, San Bernardino, and San Diego will all have populations of approximately three million or more.

Los Angeles, with an estimated population of 9.5 million, accounts for nearly one-third of all Californians, and had a population greater than all but seven states in the United States. By the year 2020, Los Angeles is expected to have a population of nearly 13 million.

Growth Projections for Selected* Counties (1996 to 2020)



*Counties with 2020 populations greater than 750,000

Section Two

Health Care Expenditures and Insurance Coverage

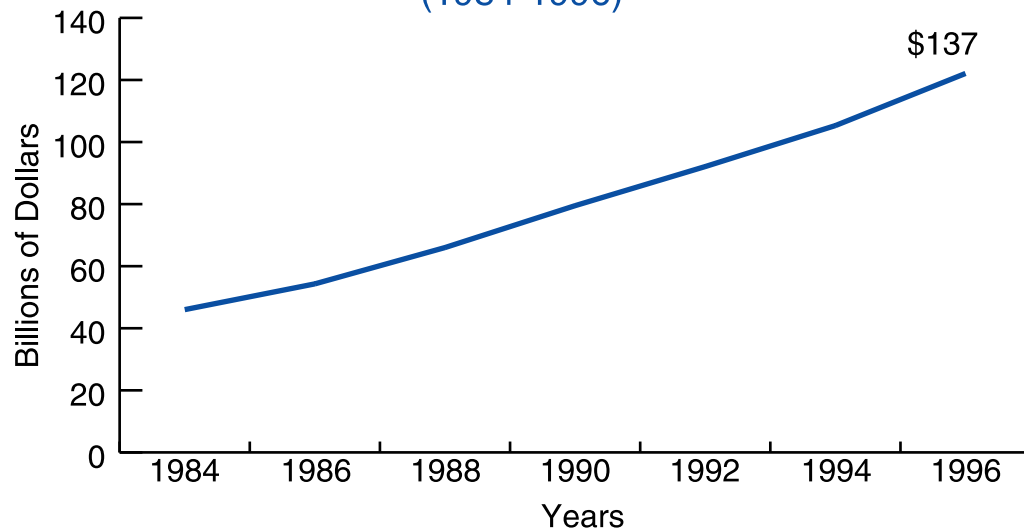
Health Care Expenditures

Total expenditures for health care in California are estimates based on various data sources, such as the Medi-Cal program, the Medicare program, the California Office of Statewide Health Planning and Development, County health programs, and private insurers.

In making health care expenditure projections, assumptions are made about a number of underlying factors that influence the economy and health care demand and supply. Health care spending continues to rise. It accounts for approximately 12 percent of California's Gross Domestic Product. An estimate released in 1996 indicated Californians spent over \$137 billion on health care that year, more than doubling the amount spent ten years earlier. A similar study projected an increase to nearly \$200 billion by the year 2000, in the absence of major policy changes.

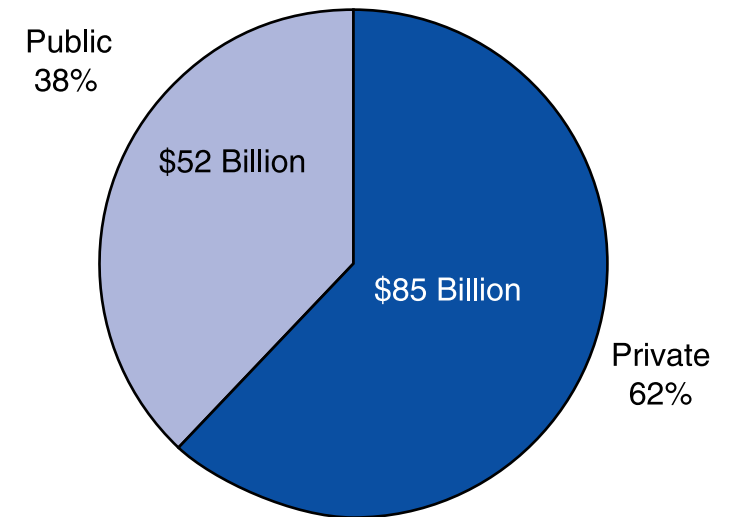
Health Care Expenditures

(1984-1996)



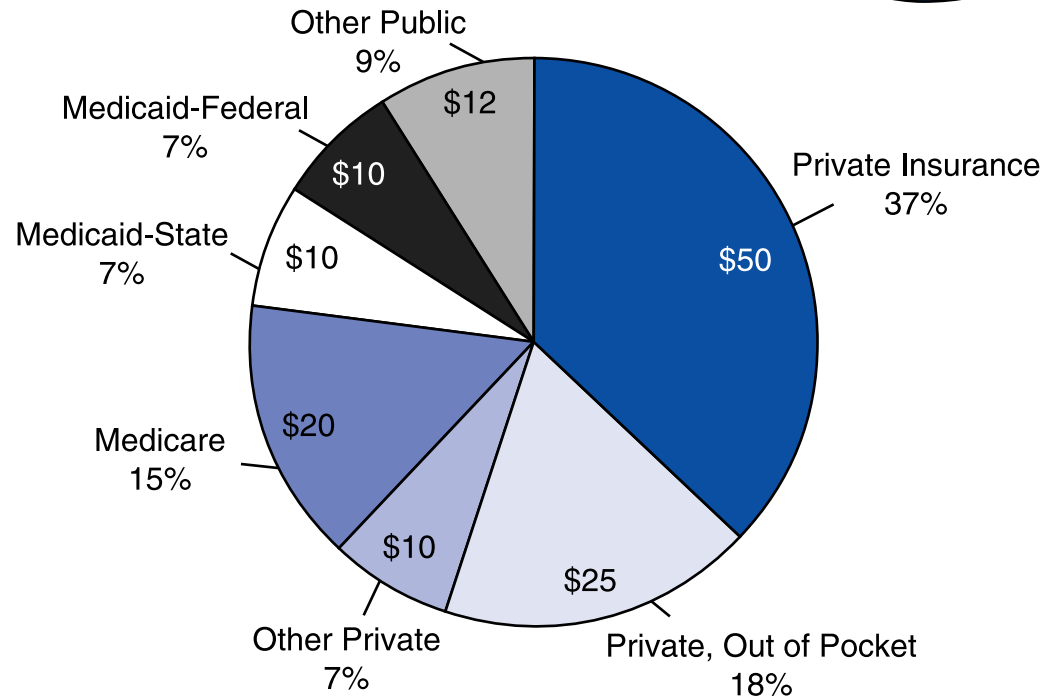
Public / Private Expenditures for Health Care

(1996 - \$ in billions)



Health Care Expenditures by Payer Category

(1996 - \$ in billions)



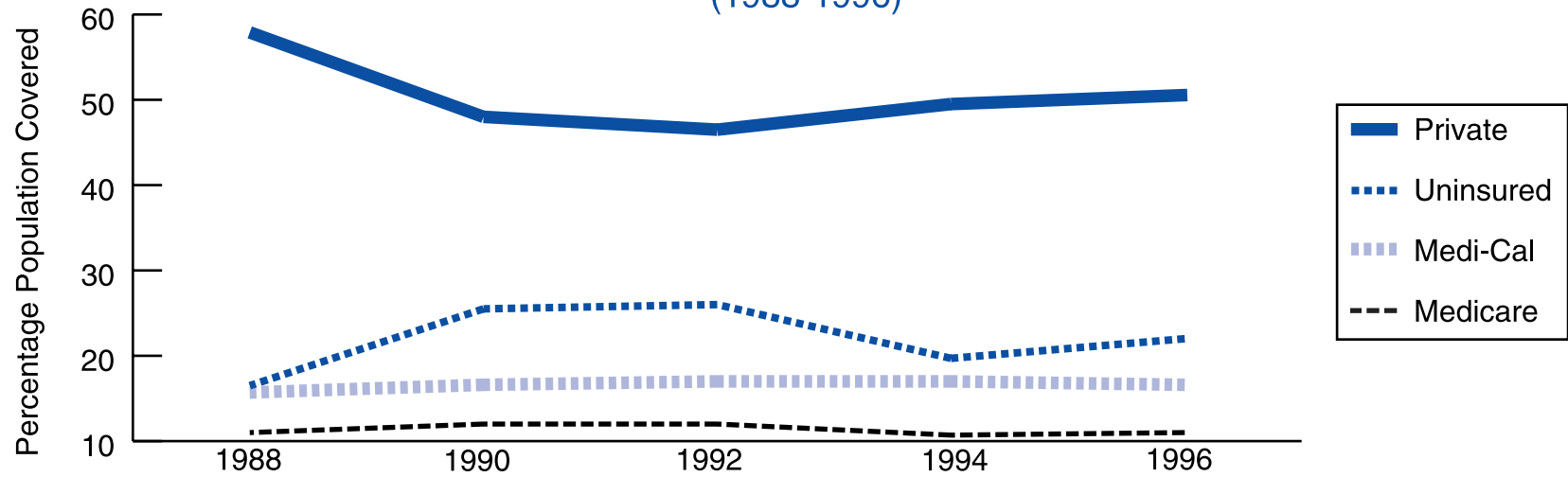
Health Insurance

Almost one quarter of the state's 33,000,000 residents has no form of health insurance. One-third of this group, or about 2,062,500, has no connection to employment; that is, they are not employed or a dependent of an employed person. Of the remaining 6,187,500 uninsured Californians, forty percent, or about 2,475,000 are full-time, year-round employees.

From 1988 to 1992, the proportion of the state's population covered by private health insurance declined and the number of Californians without health coverage increased. More recent health plan enrollment figures show increases in the number of insured Californians. During the same period, Medi-Cal and Medicare coverage remained relatively constant.

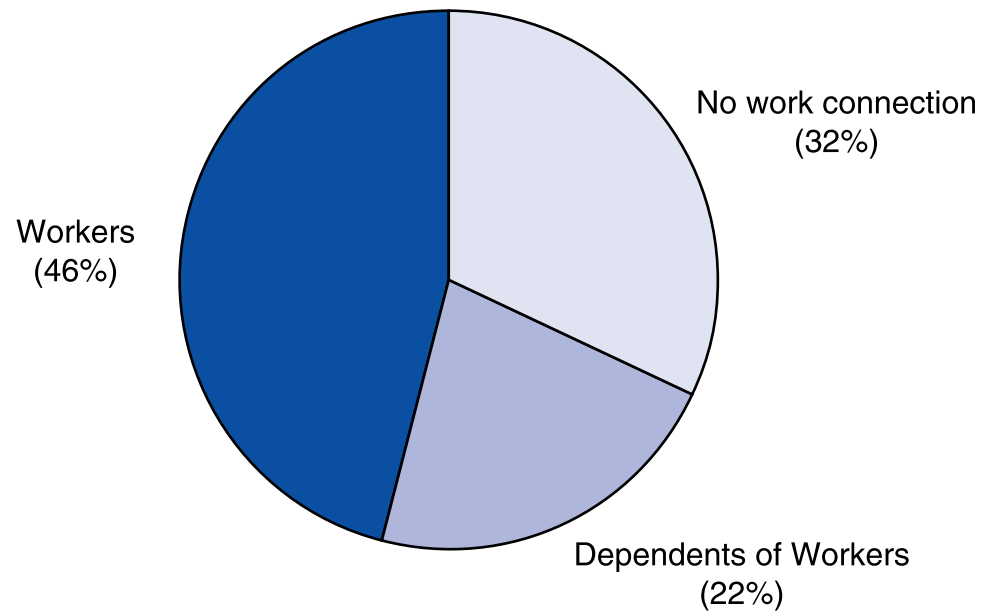
Trends in Health Insurance Coverage

(1988-1996)



Employment Status of Uninsured

(1994)



Health Insurance (continued)

Health insurance coverage for an estimated 63 percent of Californians is provided by health care service plans (health plans), sometimes referred to as health maintenance organizations (HMOs). In 1997, nearly 21 million* Californians were members of the State's 51 full service health plans paying a flat monthly rate for coverage of primary and acute health care services. Most receive coverage through their employers but Medi-Cal and Medicare are increasingly providing HMO coverage. The top 10 HMO plans account for 21.9 million Californians; Kaiser remains the largest, with 5.8 million.

* As of September 30, 1997.

Ten Largest Health Plans (HMOs) in California - 1998*

Health Plan	Enrollment
Kaiser Foundation Health Plan	5,820,762
Medpartners Provider Network	3,897,956
Blue Cross of California	3,375,058
Health Net	2,279,391
PacifiCare of California	2,161,255
California Physicians' Service (Blue Shield of California)	1,794,343
Prudential Health Care Plan of California	959,108
Cigna HealthCare of California	693,231
Local Initiative Health Authority for Los Angeles (LA Care Health Plan)	498,876
Aetna Health Plans of California	476,738

* As of June 30, 1998

Health Insurance (continued)

Approximately 20-25 percent of Californians receive health insurance through two government-funded programs: Medicare and Medi-Cal. Medicare is a federally-funded program which provides health care coverage primarily to persons who are over the age of 65, or who are permanently disabled. Medi-Cal is funded by the federal Medicaid program and the State of California. It serves families and other persons who receive cash grants through programs such as Aid to Families with Dependent Children (AFDC), now called Temporary Assistance to Needy Families (TANF), or Supplemental Security Income (SSI). In addition, certain other persons who are unable to pay for health care are eligible for Medi-Cal coverage.

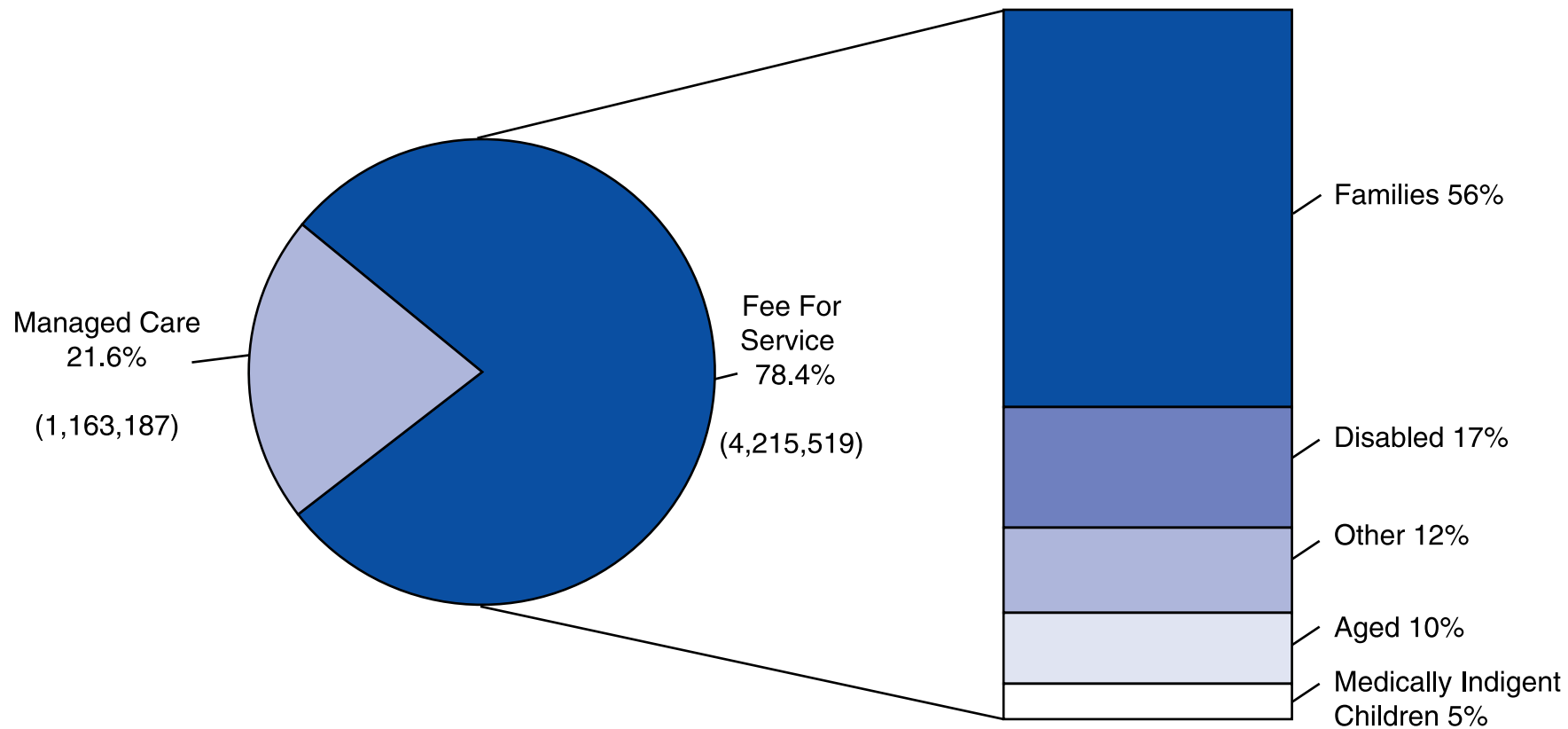
The total number of persons who applied and were determined eligible for Medi-Cal grew steadily from 1988 through 1994, peaking in fiscal year 1994/95 at approximately 5.4 million persons. Approximately 22% of Medi-Cal beneficiaries received services through managed care arrangements in 1996. This percentage will increase as the Medi-Cal program continues to move more toward managed care.

The new Healthy Families program targets coverage for an additional 400-600,000 children either in Medi-Cal or a state-subsidized private insurance program.

Medi-Cal Beneficiaries

Total = 5,378,706

(1996)



Section Three

Health Care Resources

Physicians

Traditionally, physicians play the lead role in health care delivery. Over the past two decades, the number of physicians increased at a faster rate than the State's population. In 1995, California had 77,732 practicing physicians and a ratio of one physician for every 364 persons, compared with one in 457 persons twenty years earlier. California has had more physicians per person than the nation as a whole, although the difference has narrowed. Nationally, the ratio was one physician for every 593 persons in 1975, and one for every 374 persons in 1995.

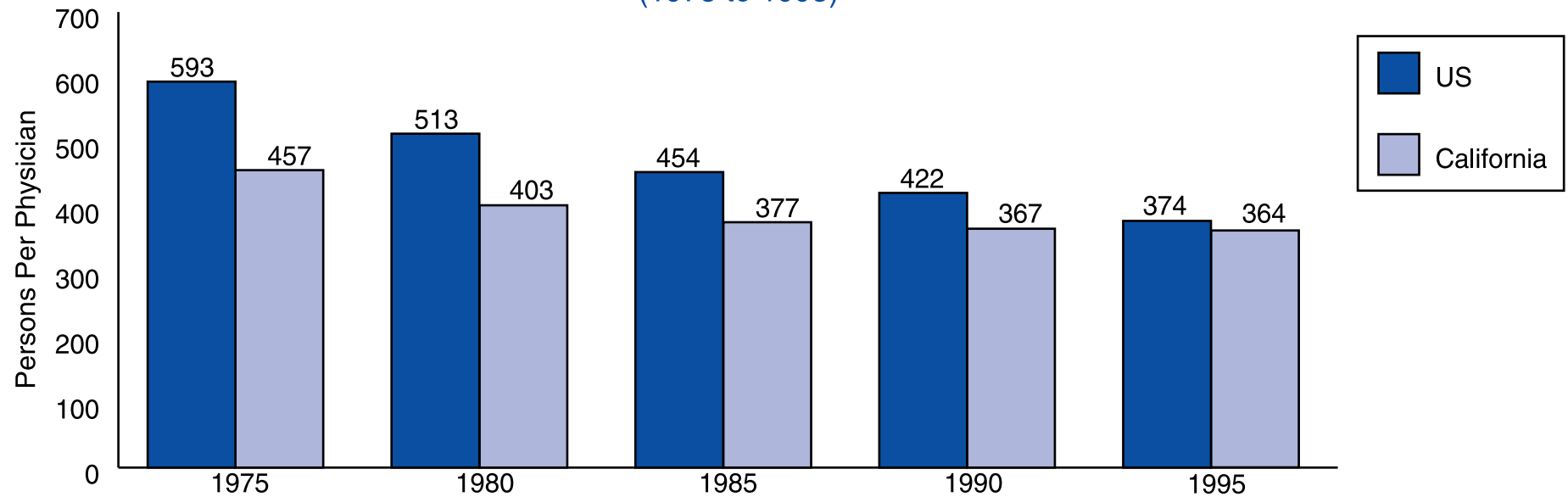
There are no universally accepted standards for the appropriate number of physicians required to adequately serve any given population. However, there is general agreement that, on a statewide basis, California has sufficient physicians to serve all of its residents. In spite of the overall adequacy of physician supply, three areas of concern are raised when the state's physician supply is analyzed more closely: 1) the imbalance between primary care physicians and specialists, 2) an uneven geographical distribution of physicians, and 3) a relative lack of minority physicians.

Specialty Distribution: Generally, physicians can be divided into two groups: those providing primary care and those who are specialists. Only 37 percent of California physicians are providing primary care--serving as personal physicians who provide patients with general health care and preventive services. This group includes general practitioners, family physicians, general internists, and general pediatricians. Obstetricians/gynecologists are often considered to be primary care physicians, as well. National goals call for 50 percent of all physicians to practice in primary care. Measured against this goal, California's proportion of primary care physicians should be increased, and specialists decreased.

Fifty-nine percent of practicing physicians are medical or surgical specialists who generally see patients upon referral from a primary care physician. Some examples are general surgeons, cardiologists, anesthesiologists, orthopedic surgeons, psychiatrists and dermatologists.

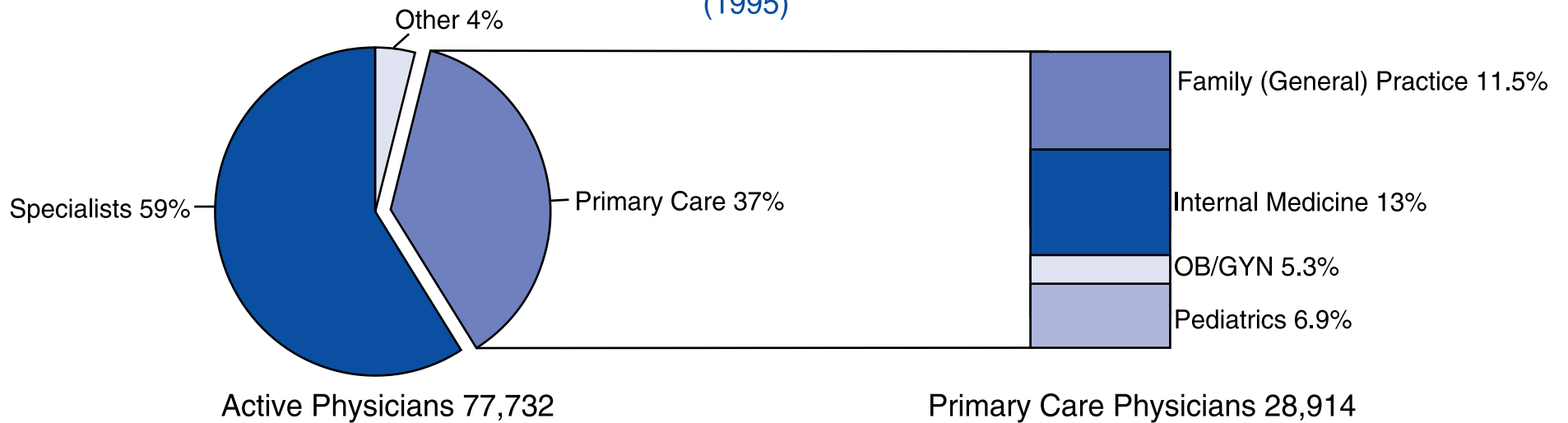
Population Per Physician Comparisons

(1975 to 1995)



Type of Practice

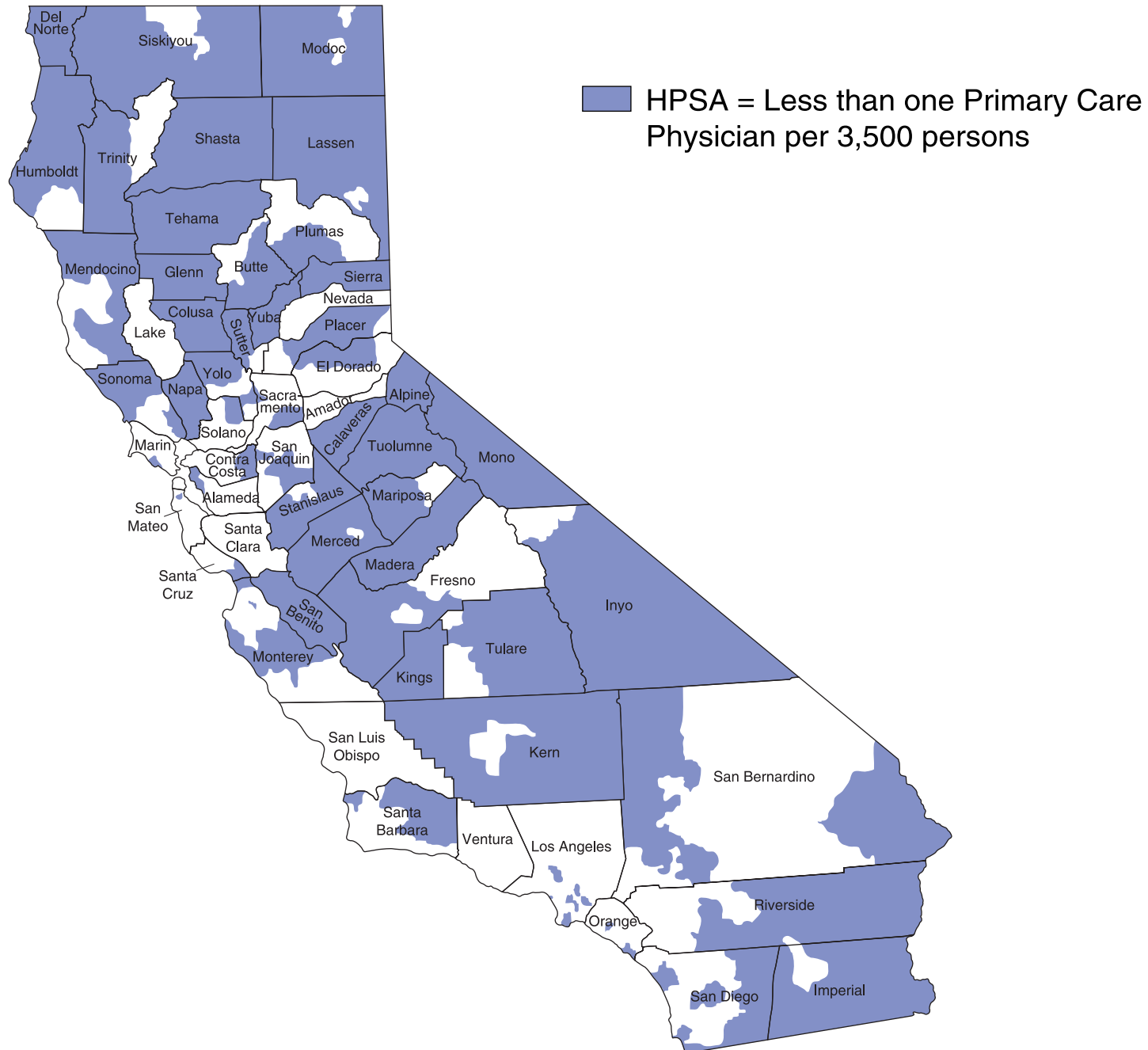
(1995)



Physicians *(continued)*

Geographical Distribution: An estimated five to six million Californians live in areas designated by the federal government as primary care shortage areas. These areas generally have less than one primary care provider for every 3,500 residents (the State average is approximately one per 1,000). Areas of shortage occur in two very different types of settings — densely populated inner city areas, where pockets of underserved areas exist in otherwise physician-rich cities, and in rural areas.

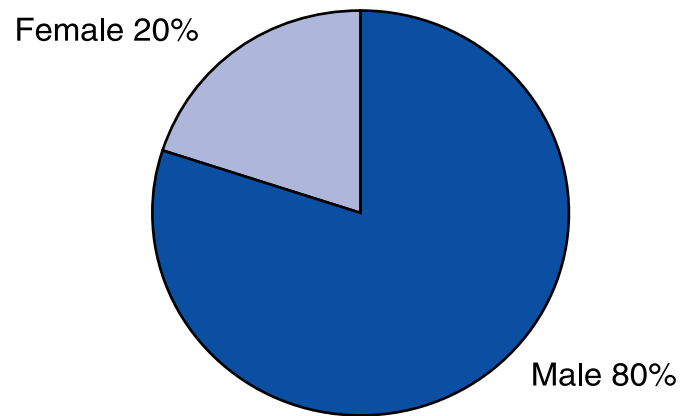
Primary Care Health Professional Shortage Areas (HPSA)



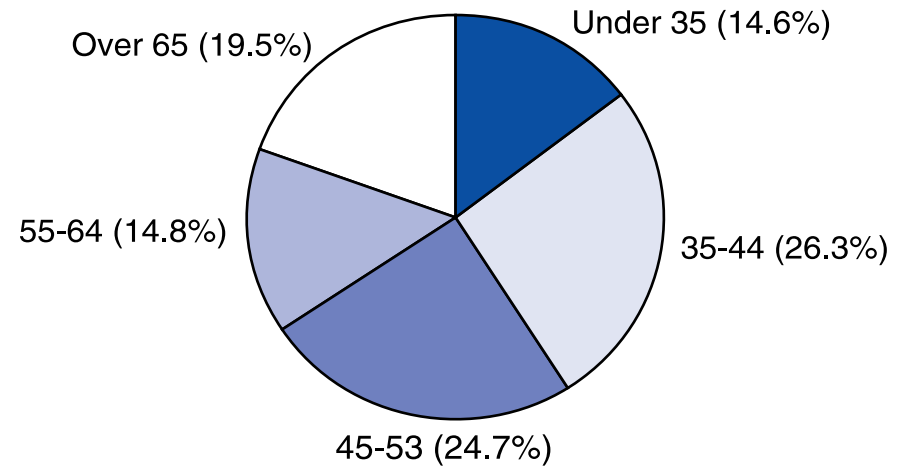
Physicians *(continued)*

Physician Demographics: The current demographics of California physicians are not representative of the state's population as a whole. In terms of gender, physicians are more likely to be male. However, this is changing as more women are now enrolled in medical schools than in the past. In terms of age, physicians are, on average, older than the general population; almost 35 percent of the California physician work force is over age 55. In terms of the ethnic backgrounds of California physicians compared to the population as a whole, Black and Hispanic are under-represented.

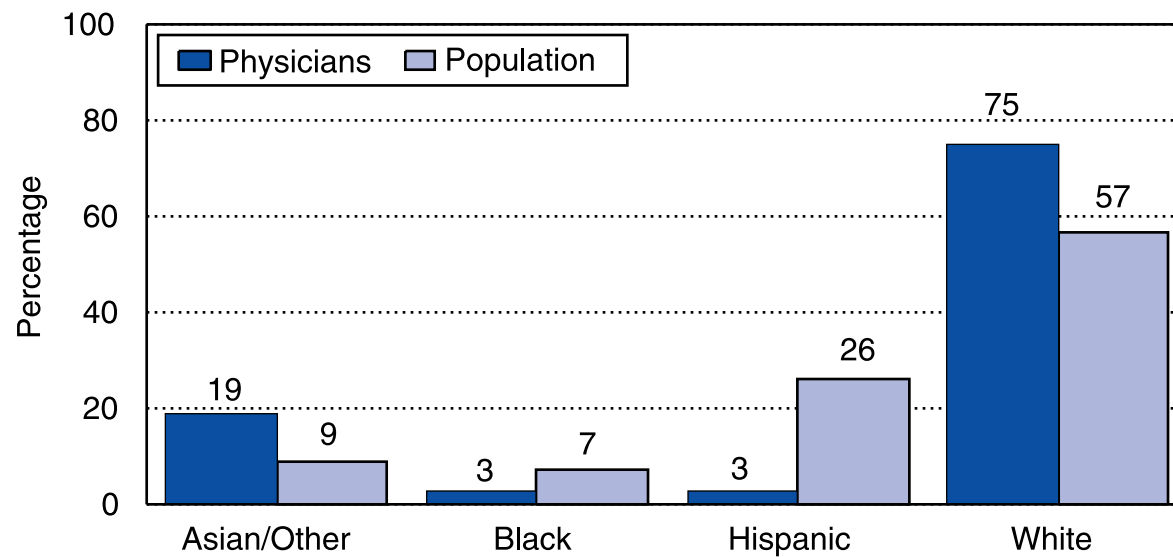
Gender of Physicians (1995)



Age of Physicians (1995)



Ethnicity (Physicians versus the State Population)



Other Health Care Providers

In addition to physicians, patient care teams are made up of many other professionals. Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) function as key members of health care teams and provide care in a variety of settings including hospitals, other health facilities, clinics, and physicians' offices. Nurse practitioners (NPs) provide primary care in collaboration with physicians, and work with other health professionals to deliver preventive services and manage chronic diseases. Physician Assistants (PAs) provide care under the supervision of licensed physicians and perform a wide range of duties from basic primary care to assisting in surgical procedures.

Dental care teams consisting of dentists, dental hygienists and dental assistants provide preventive and restorative dental care to patients in office and clinic settings. While there was a ten percent decline in the number of dentists, the number of dental assistants increased over the past two years.

Other categories of professionals such as marriage/family counselors, psychologists, physical therapists and pharmacists provide patient care and education within their own specific areas of expertise.

Other Health Care Providers

(1997)

PROFESSION	ENROLLMENT
Dentistry:	
Dentists	24,530
Registered Dental Hygienists	11,010
Registered Dental Assistants	26,310
Nursing:	
Registered Nurses	227,582
Nurse Practitioners	7,282
Nurse Midwives	807
Public Health Nurses	36,011
Nurse Anesthetists	973
Licensed Vocational Nurses	61,552
Pharmacists	20,564
Physician Assistants	2,728
Psychologists	10,268
Marriage/Family Counselors	21,400
Psychiatric Technicians	10,360
Physical Therapists	12,043
Respiratory Care Practitioners	12,799

Health Professional Education

Post Secondary Education: California has excellent educational resources for training virtually every category of health professional. Appendix B provides a listing of the State's medical, dental, pharmacy, nursing and physician assistant training programs. These programs are located in either the University of California and California State University systems or in private four-year universities and colleges.

In addition, there are numerous other health professional training programs in the State which train allied health professionals. Many are located in the State's community colleges. Others are in private institutions. Examples of the types of health professionals trained include: licensed vocational nurses, home health aides, medical assistants, dental assistants, medical laboratory technologists, and respiratory therapists.

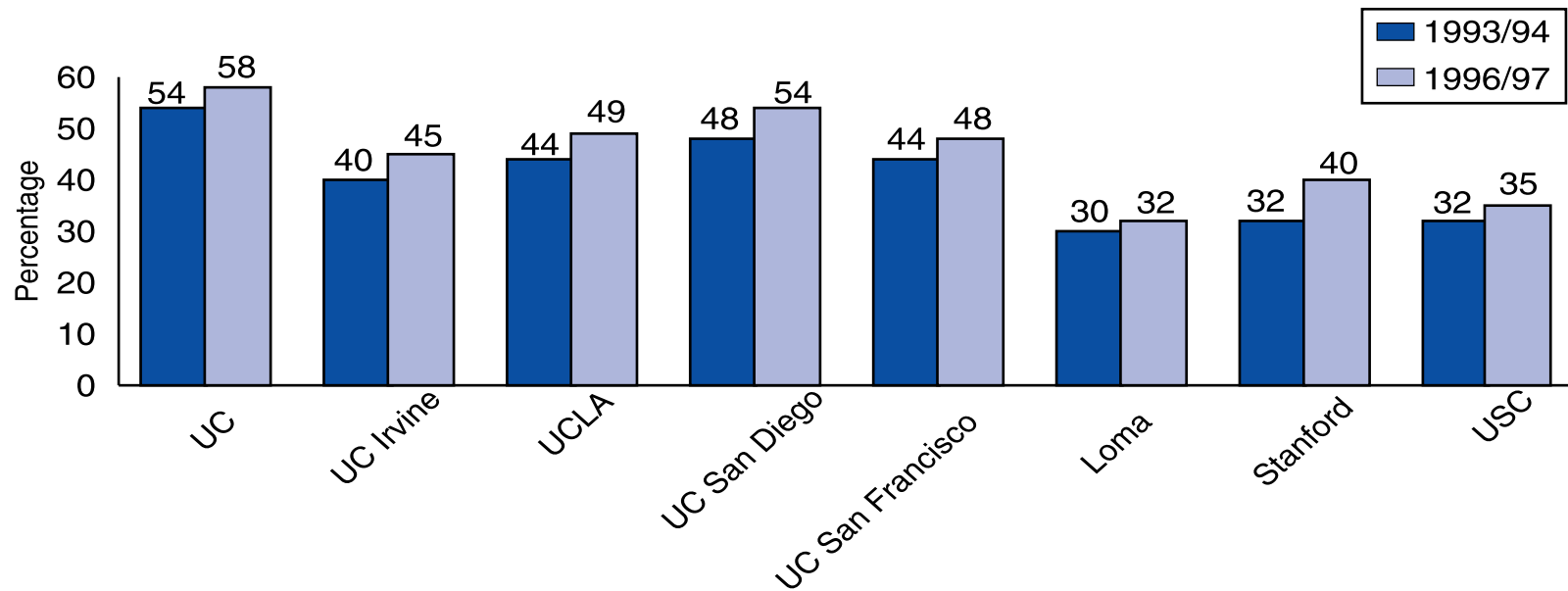
Residency Training Programs: California has over 600 medical residency training programs that train nearly 10,000 residents and other clinical trainees in over 100 medical specialties. Most of these programs are either based at or affiliated with one of the nine medical schools in the State--56 percent with University of California's five medical schools.

Over five million people in California live in areas with insufficient numbers of primary care physicians. In recognition of this lack of primary care, the University of California agreed in 1993 to increase the number of its residents in family medicine, general internal medicine, general pediatrics, and obstetrics/gynecology to achieve a goal of at least 50 percent of all its residents in primary care specialties. This goal also required the university to reduce the number of residents in the non-primary care specialties. The numbers reported to OSHPD by the University indicate that this goal was close to achievement in the 1996-97 academic year. In contrast, for that same year, the three private schools in aggregate reported that only 35 percent of their medical residents were in primary care. Drew University, a private medical school affiliated with the University of California, reported 43 percent of its residents in primary care.

The increase in primary care medical residents reflects not only the efforts by the University of California, but also reflects the impact of managed care (with its emphasis on primary and preventive care) on the health care marketplace. Medical school graduates are choosing primary care in increasing numbers.

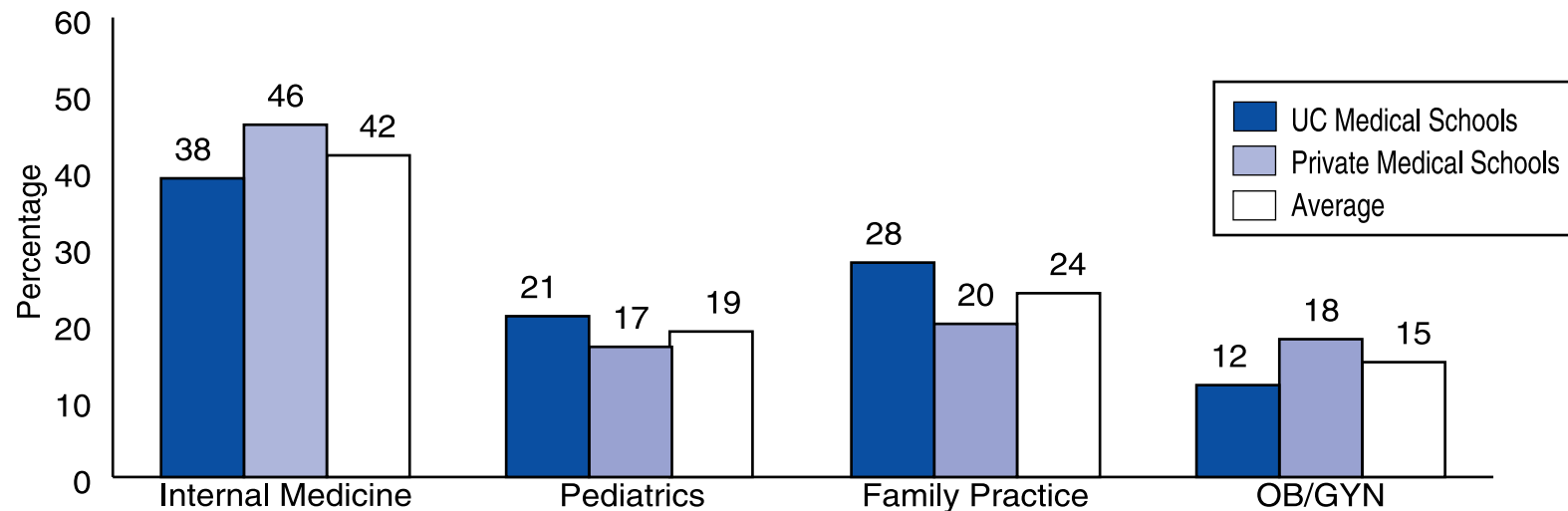
Percent of Medical School Graduates Entering Primary Care

(1993/94 vs. 1996/97)



Primary Care Fields Chosen by Medical School Graduates

(1994)



Hospitals

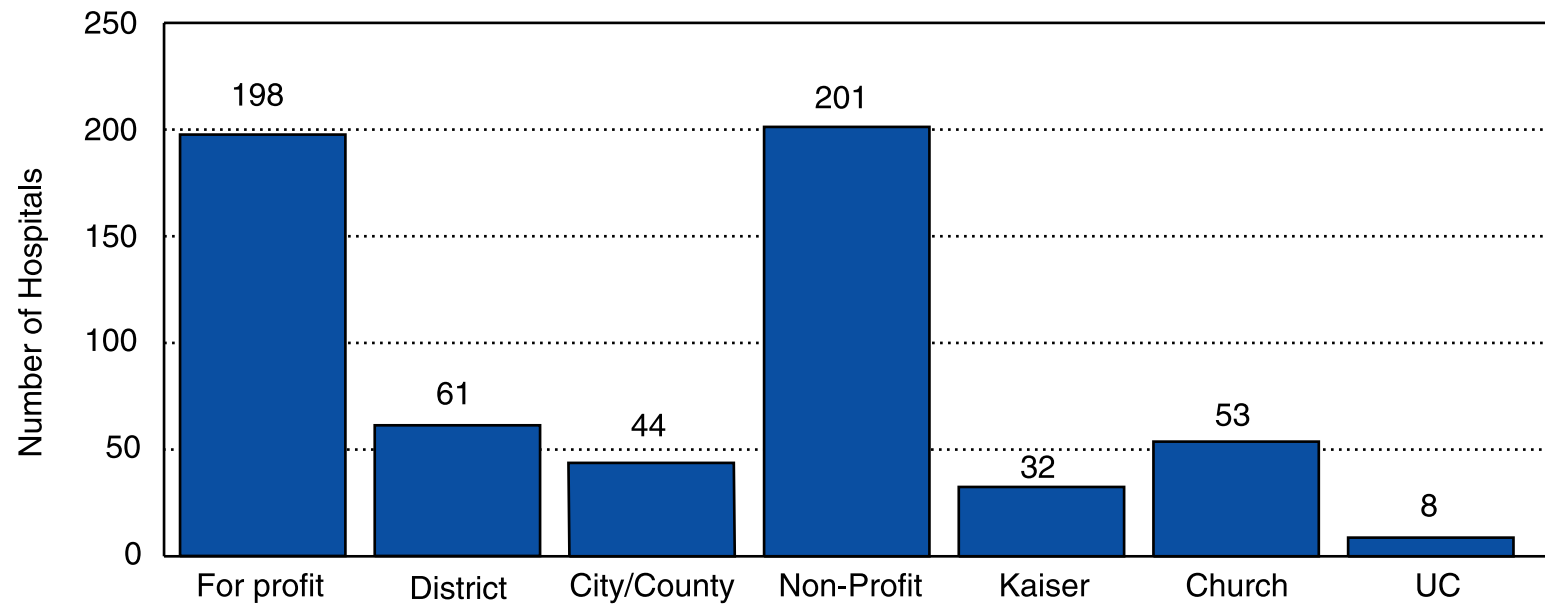
In 1996, California had 597 licensed hospitals with nearly 102,000 beds--about one bed for every 324 Californians (or, as it is more commonly stated, 3.1 beds per thousand persons). Of these, 399 or 67 percent were non-profit hospitals, including government, church and university facilities.

About 500 of the State's hospitals are categorized as general acute care (GAC) hospitals. These types of facilities are licensed to provide a full range of medical and surgical care to both adult and pediatric patients. Within this group, there is wide variation in the type and complexity of services provided to patients. Most GAC hospitals (80 percent) have emergency rooms that provide care to the injured or ill patient who requires immediate medical attention. Only 41 of these hospitals are designated as trauma centers, which are staffed and equipped to care for the most serious accidents and injuries. Twenty-seven GAC hospitals are major teaching hospitals--equipped to train medical interns and residents, and offer the most complex types of medical and surgical services to patients. Many other GAC hospitals provide a more basic mix of services including medical care, routine surgery, and birthing services.

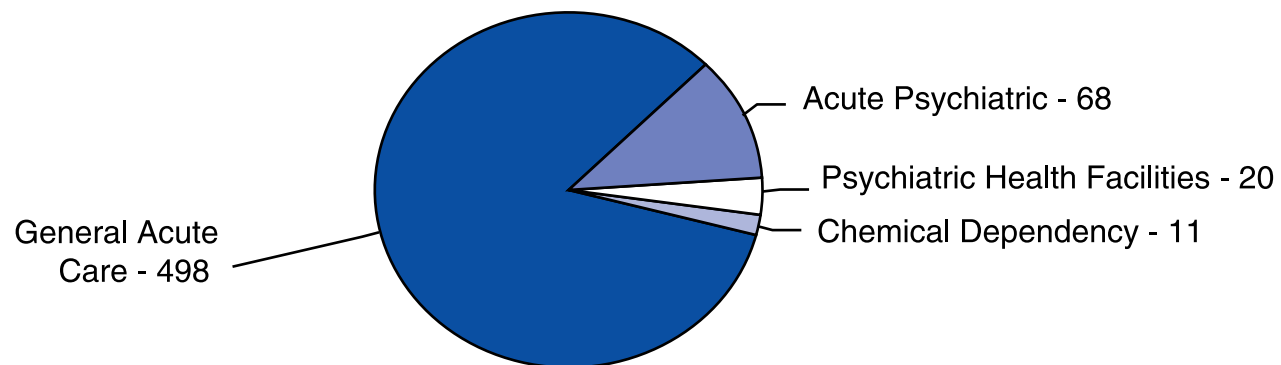
Hospitals in rural areas tend to be smaller than hospitals in urban areas and generally provide medical and surgical services of a less complex nature. In rural hospitals, critically ill patients or those in need of specialized services are stabilized and then transferred, when necessary, to a facility which offers the needed level of care. Many rural hospitals are a main source of health care and emergency services in their regions and also have the capacity to provide long-term nursing care.

Slightly over ten percent of California hospitals specialize in providing psychiatric care. In addition, there are a small number of hospitals that specialize in care exclusively for children and others that serve only patients with certain specialized needs, such as chemical dependency treatment or rehabilitation services.

Ownership of California's Hospitals (1996)



California's Licensed Hospitals (1996)



Hospitals (continued)

During the 1996/97 fiscal year, hospitals* in California received more than \$28 billion in payments for patient care--over \$1.3 billion more than in fiscal year 1993/94. More than one-half of these payments were from government-sponsored programs (mainly Medicare and Medi-Cal). About 40 percent were from private insurers. The remaining revenue came from self-pay patients or those covered by special funding sources, such as clinical teaching funds.

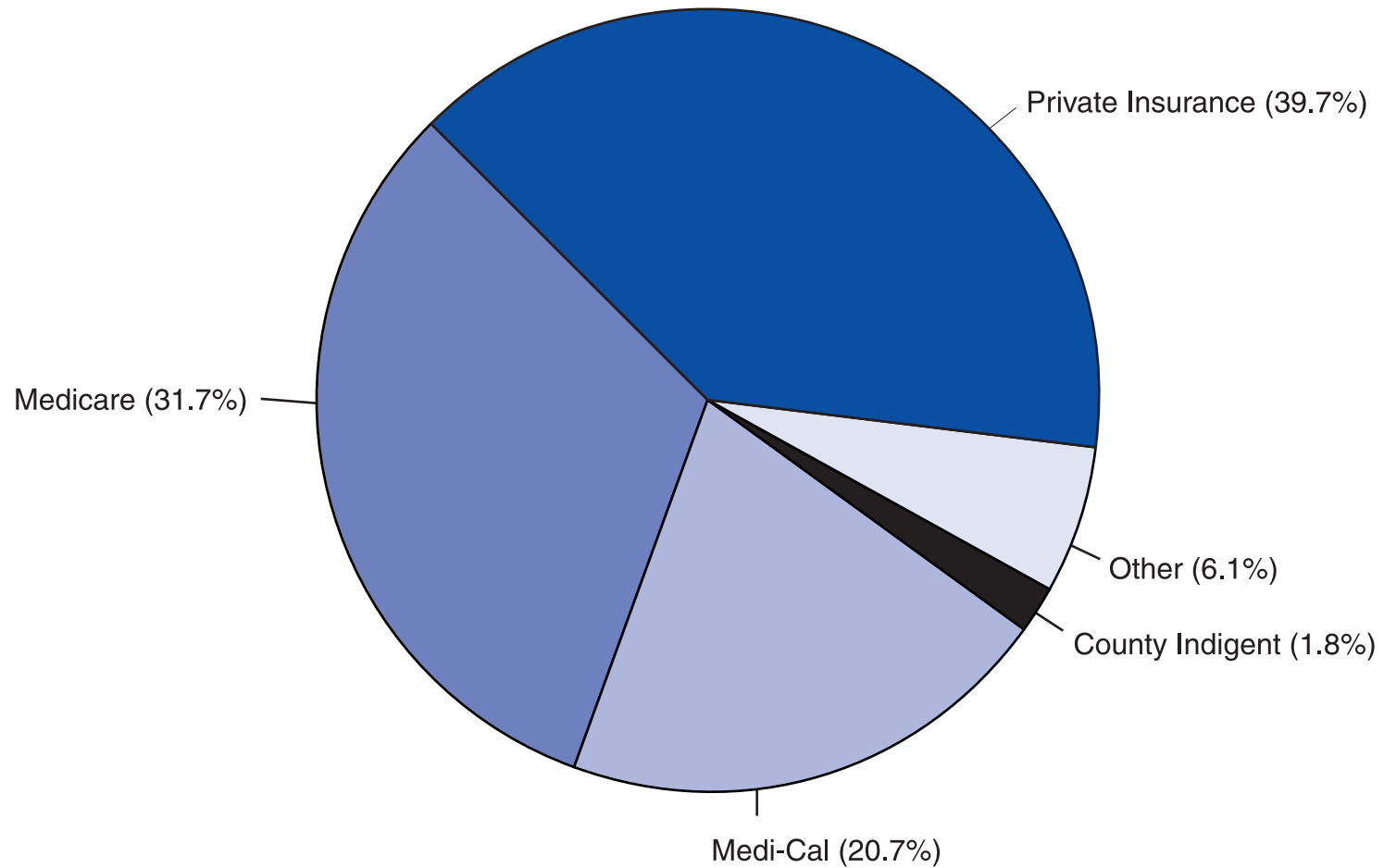
Nearly 75 percent of net patient revenue was associated with inpatient care. Hospitals received an average of \$7,386 per discharge for the 2.8 million patients discharged (excluding nursery) during the year. Average daily net revenue was \$1,307 per patient. Outpatient care resulted in \$7.3 billion in hospital net revenue, or an average of \$187 per outpatient visit.

** Excludes prepaid health plan hospitals (Kaiser and others), State hospitals, long-term care emphasis hospitals, psychiatric health facilities, and three other hospitals which report non-comparable financial data to the Office of Statewide Health Planning and Development. Also excluded are federal hospitals which are not required to report to the State.*

Hospital Net Revenue by Payer Source

(1996/97)

Total=\$28 Billion



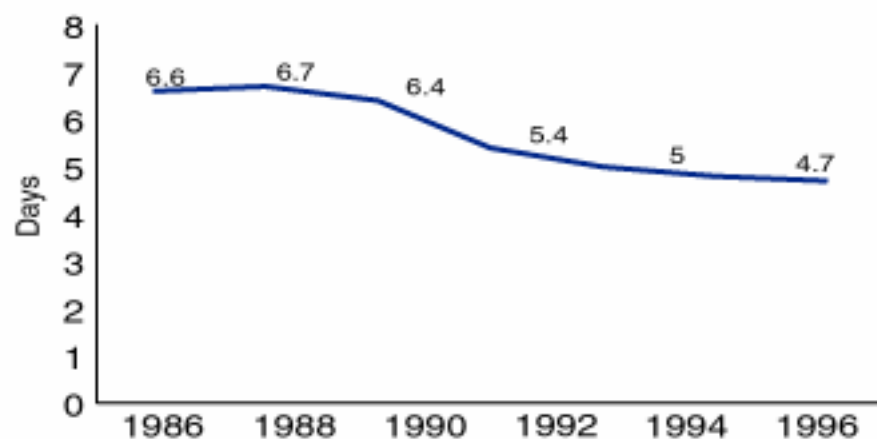
Hospitals (continued)

The number of patients admitted to California hospitals has remained relatively constant at around 2.8 million per year, but the Average Length of Stay (ALOS) in the hospital has decreased steadily as a result of cost containment strategies. In 1986, the ALOS was over 6.5 days; by 1996, it had dropped to 4.7 days.

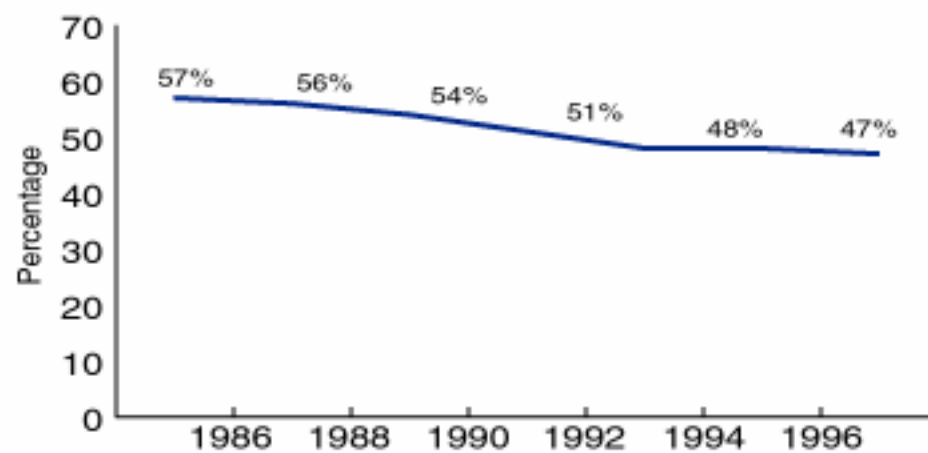
Furthermore, hospitals are experiencing a dramatic shift in the relative proportions of inpatient and outpatient surgical procedures. In 1986, the number of inpatient procedures performed in hospitals exceeded outpatient procedures by about 300,000. However, in the intervening years there has been a steady decline in inpatient procedures, while outpatient procedures have increased. Hospitals are now performing about 150,000 more outpatient surgeries per year than inpatient. Not only has the number of outpatient procedures increased, but the location of many such procedures has actually moved from the hospital altogether to freestanding ambulatory surgery centers and physicians' offices.

These trends have a significant impact on the occupancy of hospital beds in California and throughout the nation. In 1986, less than 60 percent of available hospital beds were occupied on a typical day. By 1996, occupancy had dropped to 47 percent--meaning that, on a typical day, more than half of the hospital beds in California were empty.

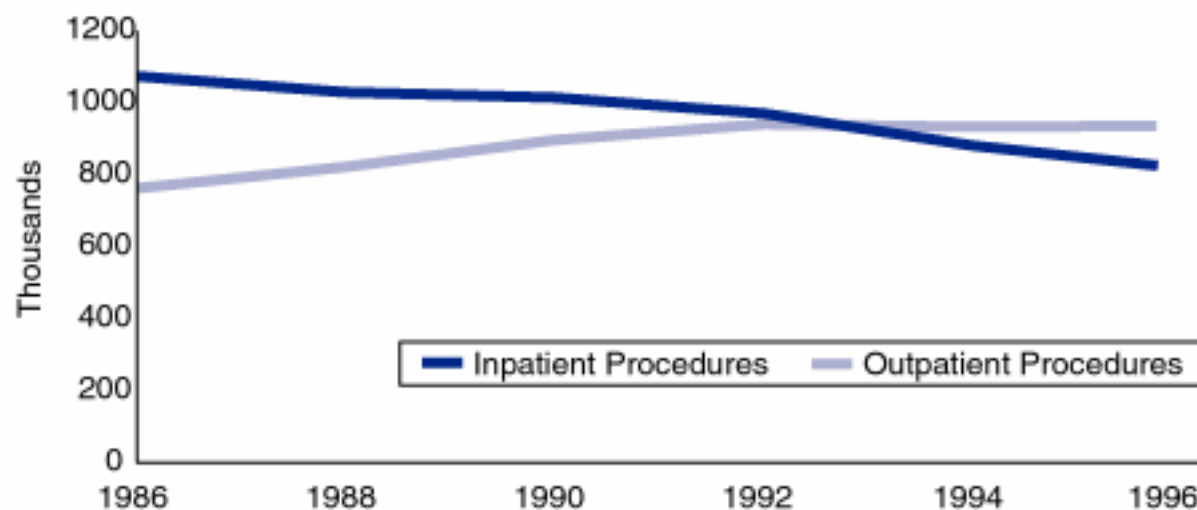
Average Length of Hospital Stay
(1986-1996)



Occupancy of Available Beds
(1986-1996)



Inpatient and Outpatient Surgical Procedures
(1986-1996)



Hospitals (continued)

In 1996, there were almost 525,000 hospitalizations associated with births in California. Normal delivery was the most common reason* for hospitalization (over 400,000) and birth by cesarean section was the third most common. Severe mental illness (psychosis) was the second most common reason for hospitalization, accounting for nearly 142,000 hospitalizations a year. Other common reasons for hospitalization were pneumonia, heart disease and strokes.

Cesarean section is the most commonly performed surgical procedure in California hospitals. Other common procedures include circumcisions, hysterectomies, appendectomies, and gall bladder removals. Wound debridement following burns, coronary angioplasty, and knee replacement are among the most costly.

In terms of overall cost, transplant surgery far exceeds the cost of other hospitalizations. Daily charges are generally two-to-four times the average charge, and lengths of stay are extraordinary. When compared to costs from three years prior, transplant costs have generally decreased as a result of shorter lengths of stay and, in some cases, lower average charges per day. The exception is bone marrow transplants, where the average charge shows a noteworthy increase from three years before of over \$100,000 per stay. The average hospital charge for a bone marrow transplant in 1996 was \$323,000 compared to \$221,000 in 1993. This covers only the charges made by the hospital and does not include professional fees of surgeons, anesthesiologists, and other physician specialists.

** The number of discharges associated with deliveries is based on several Diagnostic Related Groups (DRGs). All other reasons for hospitalizations are based on the highest frequency of a single DRG.*

Top 10 Reasons for Hospitalization (1996)

Diagnosis	Number of Hospitalizations	ALOS (Days)	Avg. Charge Per Day	Avg. Charge Per Stay
Normal Delivery*	416,350	1.5	\$2,928	\$4,370
Psychoses	141,775	10.0	\$1,090	\$10,953
Cesarean Sections*	108,256	3.3	\$2,988	\$9,658
Heart Failure and Shock	80,271	5.5	\$2,320	\$13,089
Adult Pneumonia	59,595	6.4	\$2,158	\$14,295
Cerebrovascular Disorders (Incl. stroke)	59,498	8.4	\$1,841	\$16,202
Joint Procedures, Leg	46,394	5.0	\$5,812	\$29,152
Chronic Lung Diseases	44,287	6.1	\$2,104	\$13,178
Percutaneous Cardiovascular Procedures	42,696	3.2	\$9,303	\$29,910
Uterus Procedures	42,068	2.6	\$4,138	\$10,731

* includes all DRGs associated with births

Most Common Surgical Procedures (1996)

Procedure	Number	ALOS (Days)	Avg. Charge Per Day	Avg. Charge Per Stay
Cesarean Section	108,256	3.3	2,988	9,658
Circumcision	55,092	1.7	1,011	1,741
Abdominal Hysterectomy	32,177	3.4	3,856	13,302
Coronary Angioplasty	32,005	3.2	9,402	30,674
Laposcopic Cholecystectomy	30,794	3.0	5,142	15,509
Appendectomy	30,293	3.3	3,652	12,328
Disc Removal (spine)	21,561	3.0	5,583	17,016
Knee Replacement	19,540	4.6	6,283	28,054
Wound Debridement	16,825	11.0	2,977	33,591
Surgical Repair/ Leg Fracture	16,626	6.1	4,074	25,107

Selected High Cost Procedures (1996)

Procedure	Number	ALOS (Days)	Avg. Charge Per Day	Avg. Charge Per Stay
Liver Transplant	609	28.2	8,905	250,880
Heart Transplant	271	28.9	8,302	239,950
Bone Marrow Transplant	506	44.1	7,333	322,518
Kidney Transplant	1,375	8.8	9,228	81,588

Long-term Care Facilities

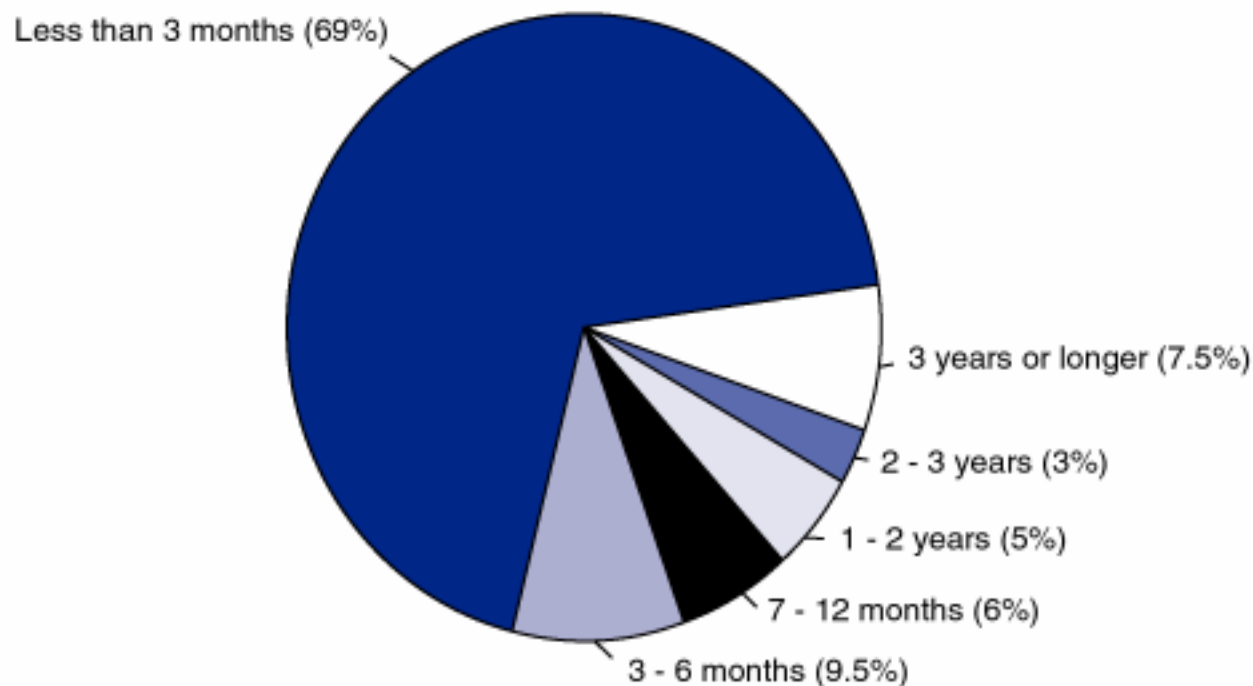
California has over 1,200 freestanding (non-hospital based) skilled nursing and intermediate care facilities. Together, these facilities have over 119,000 licensed beds. Patients in these facilities require 24-hour nursing care at a level less intense than acute care. In addition to providing nursing care for the chronically ill, many facilities also provide specialized types of care. About 42 percent of the State's long-term care facilities provide hospice care to terminally ill patients. Nine percent provide specialized care to patients with AIDS and HIV-related conditions. While 15 percent of the facilities provide intermediate care, care in congregate living facilities, and care to mentally or developmentally disabled patients, these uses account for only 7 percent of available beds.

Contrary to common perceptions, most patients remain in long-term care facilities for relatively short periods of time. Sixty-nine percent of the patients are discharged within three months. Almost 85 percent are discharged within a year of admission.

Services Provided (1996)

Type of Care	% Facilities Providing Care
Skilled Nursing	92%
Hospice	42%
AIDS/ARC/HIV	9%
Intermediate Care	6%
Mentally Disordered/ Developmentally Disabled	6%
Congregate Living	3%

Length of Stay in Long-term Care (1996)

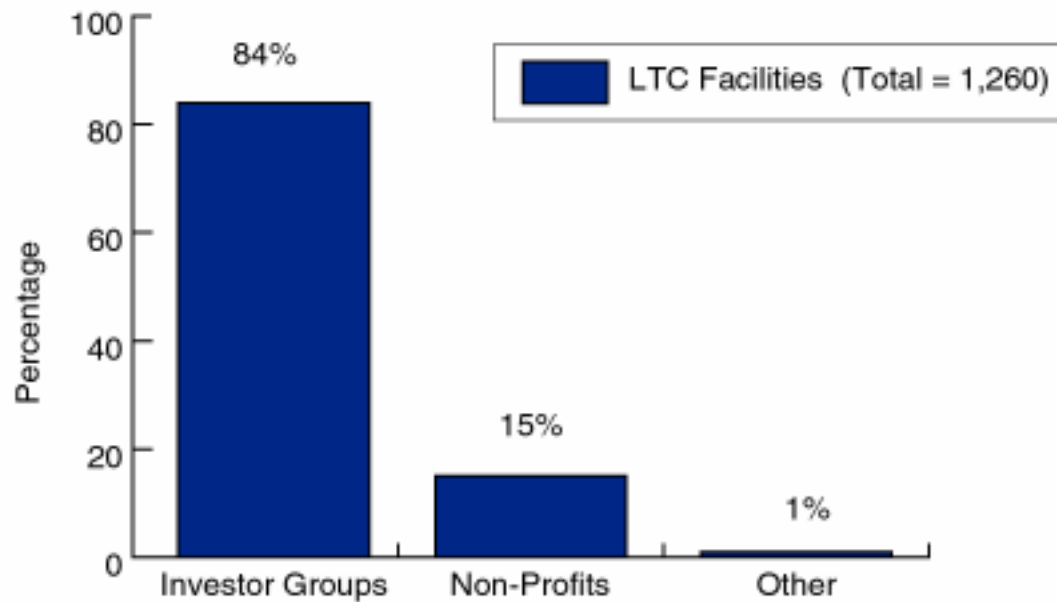


Long-term Care Facilities *(continued)*

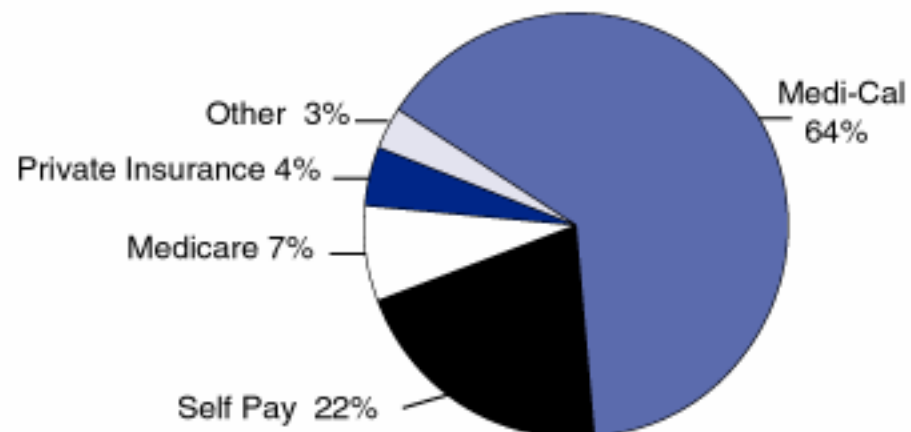
Approximately 71 percent of the 170,000 patients treated in long-term care facilities in California are paid for by public programs, largely the State-administered Medi-Cal program. Private (self) pay patients pay an average of \$120 per day or about \$3,600 per month for skilled nursing care.

In contrast to hospitals in California, which are largely owned by nonprofit or public entities, long-term care facilities are generally private, investor-owned enterprises. About 84 percent of the facilities are owned by investor groups and they provide nearly 91 percent of all Medi-Cal billed patient days. Fifteen percent of the facilities are owned by nonprofit entities.

Ownership Type (1996)



Source of Payment for Long-Term Care Patient (1996)



Home Health Services

In 1996, home health agencies provided care to 750,228 patients. Home health care patients received an average of 22 visits from providers during the course of the year. Between 1988 and 1996, the number of home health care patients increased more than 130 percent and the number of home visits increased almost 300 percent.

Home health care is provided for a wide variety of conditions. Most common are heart disease and stroke, diabetes, and cancer.

In 1996, nearly 6,600 Alzheimer patients were seen by home health providers, with an average of 25 visits per patient during the year. Over 8,600 AIDS patients received home health care services, averaging 19.2 visits per patient.

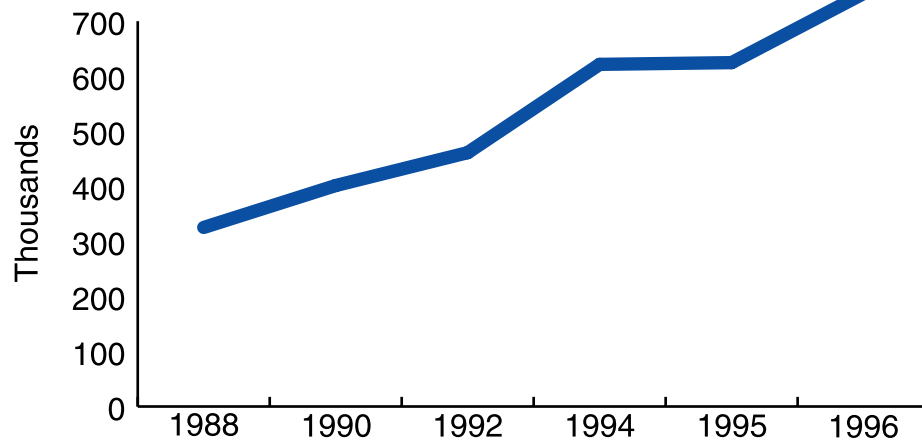
Care of a more short-term nature is also provided in the home; most commonly for pregnancy and recovery from childbirth.

A little over one-half of home health referrals are made by hospitals. Another 29 percent are made by physicians. The remainder are by agencies, payers and patients' families. Most home visits are provided by home care nurses, certified nurse assistants, and home care workers.

In 1996, Medicare and Medi-Cal paid for 85 percent of home health visits in California. Health maintenance organizations and preferred provider organizations accounted for another 7.7 percent of reimbursements. Other government payers, private insurance, or patients paid for the remainder.

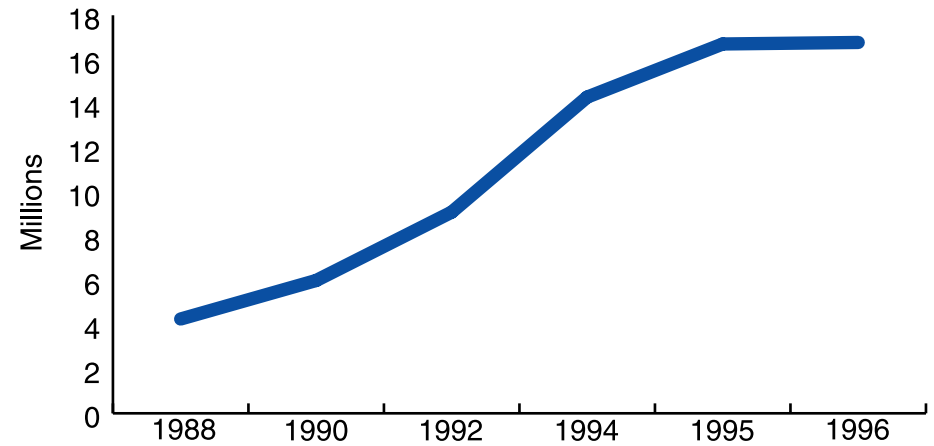
Home Health Patients

(1988-1996)



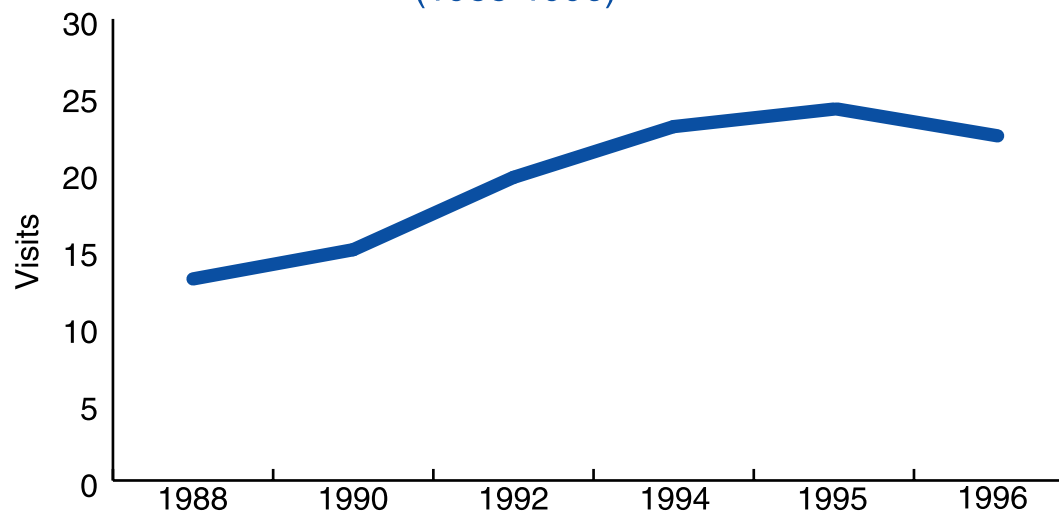
Provider Visits

(1988-1996)



Average Visits Per Patient

(1988-1996)



Primary Care Clinics

Primary care clinics offer a wide range of services which includes general medicine, preventive care, immunizations, family planning, perinatal care, HIV testing and counseling, dental care, substance abuse treatment, and mental health services.

In California, licensed primary care clinics include two types: (1) free clinics, of which there were 28 in 1996 and (2) community-based clinics, of which there were 611 in 1996. These clinics are distinct from hospital clinics or physician offices and were generally established to provide an accessible source of primary and preventive care to those unable to access other health care providers. Clinics served a total of more than 2.5 million patients in 1996, with over 9.3 million patient visits.

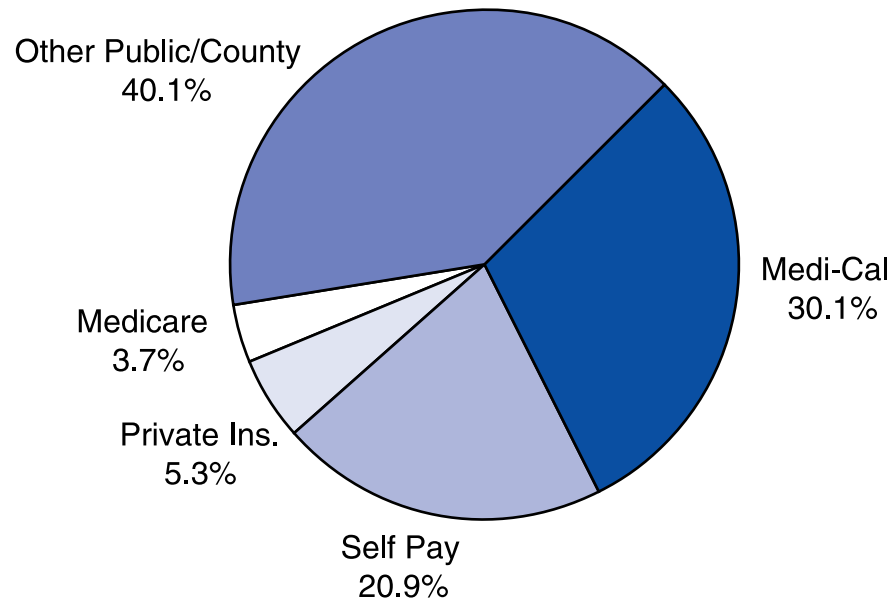
The vast majority of patients in these clinics receive care through government-sponsored programs or pay the clinic directly. Very few patients have private health insurance. Almost 87 percent of primary care clinic patients are below 200 percent of the poverty level (up from 81% in 1993) and many do not speak English as their first language. In order to accommodate patients, 545 of the 639 primary care clinics are staffed with bilingual or multilingual providers.

Specialty Clinics

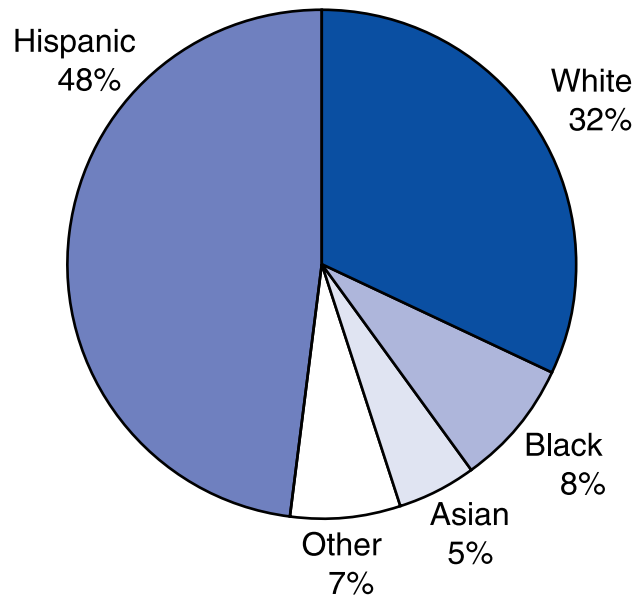
A total of 464,417 patients were seen in specialty clinics in 1996--over 100,000 more than in 1993. Many patients received services for dialysis, psychiatric, or rehabilitation care, but most were seen for outpatient surgery. A large number of surgeries now performed in specialty clinics were once provided by acute care hospitals as inpatient procedures. As new technologies were introduced and shorter recovery periods ensued, many surgical procedures could be performed more efficiently in outpatient settings. Consequently, the total number of outpatient surgeries in 1996 increased to over 1.4 million, or approximately one and one-half times the number of inpatient surgeries.

Patients of Primary Care Clinics (1996)

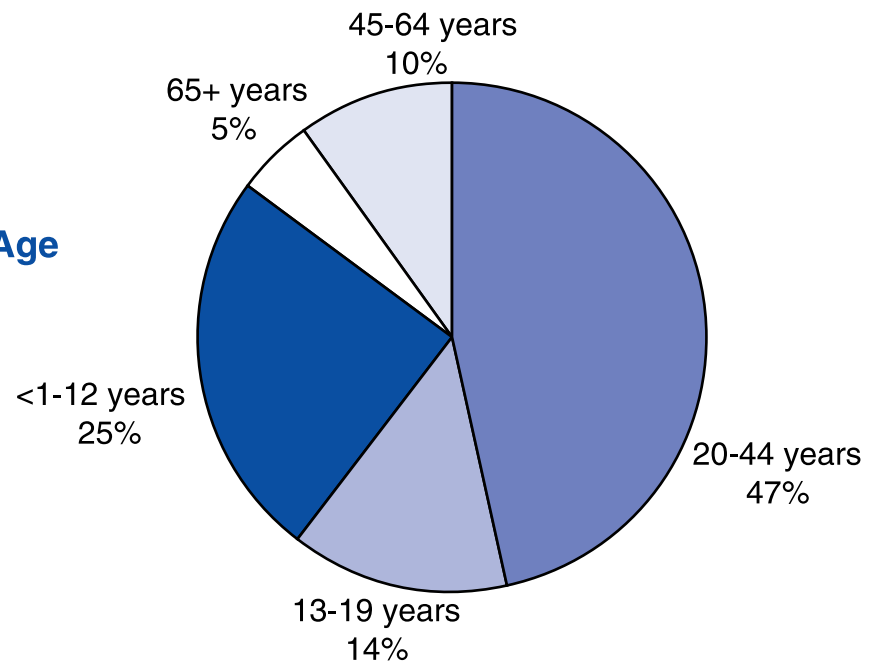
Payer Source



Race



Age



Section Four

Health Status Indicators

Births

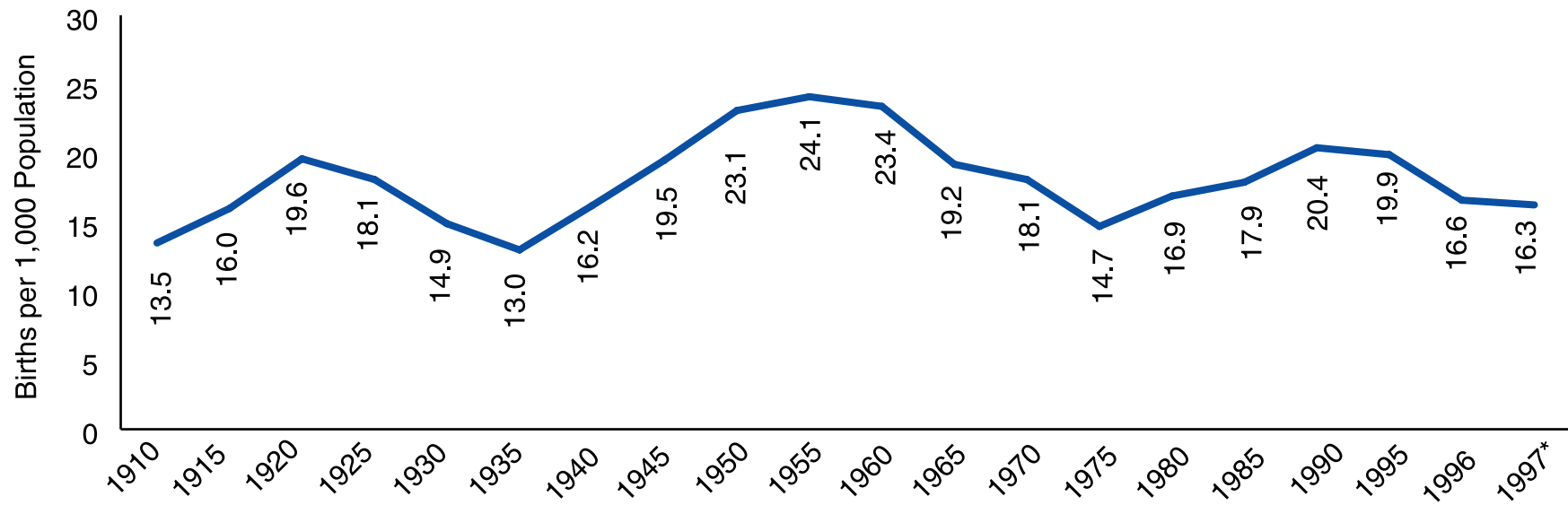
In 1996, California experienced its sixth straight year of declining births--a 2.3 percent drop from 1995 and a 12.6 percent drop from 1990. The state birth rate for 1996 was 16.6 live births per 1,000 persons. The birth rate for 15-19 year olds continues to drop markedly, a trend occurring nationwide. Rates for 20-29 year olds seem to be leveling off; rates for 30-39 year olds appear to be increasing slightly; and the birth rate for 40-44 year olds is also increasing.

California's birth rate nevertheless continues to be higher than the national rate of 14.8 births per 1,000 persons in 1996.

Since 1994, Hispanics have had the largest number and the highest percentage of births of any ethnic group in California.

In 1996, births in California accounted for approximately one of every seven of the births in the United States.

State Birth Rate (1910 to 1997)



* projected population

Births (continued)

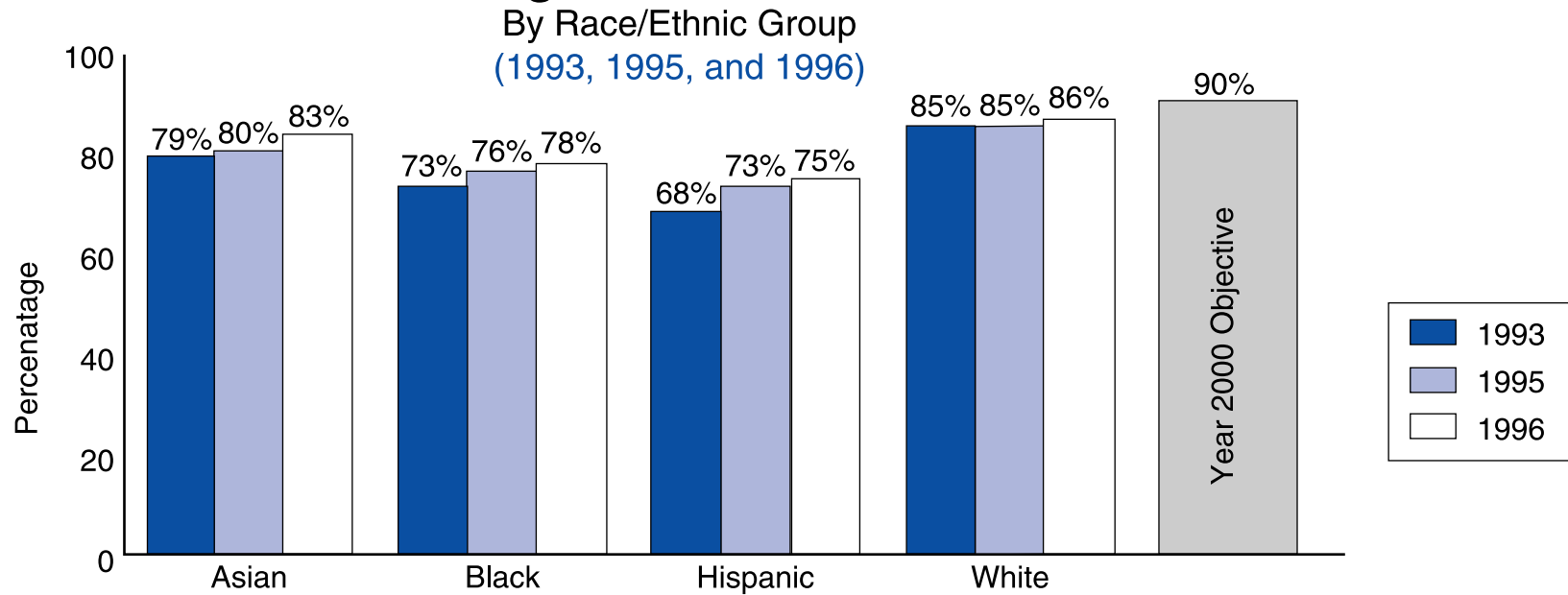
One of the most effective preventative health measures is early (first trimester) prenatal care. The *Year 2000 National Health Objective** for prenatal care is for 90 percent of all pregnant women to begin prenatal care during the first trimester of pregnancy. The proportion of pregnant women in California who received prenatal care in the first trimester in 1996 was nearly 80 percent--a noteworthy improvement from the level of 75 percent held from 1985 to 1995.

Over the past few years, increases in the number of mothers receiving early prenatal care can be seen in every ethnic group. The greatest improvement was made by Black and Hispanic mothers. Expectant teenage mothers continue to have the lowest percentage of early prenatal care, at 67.8 percent, but that group also appears to be slowly improving.

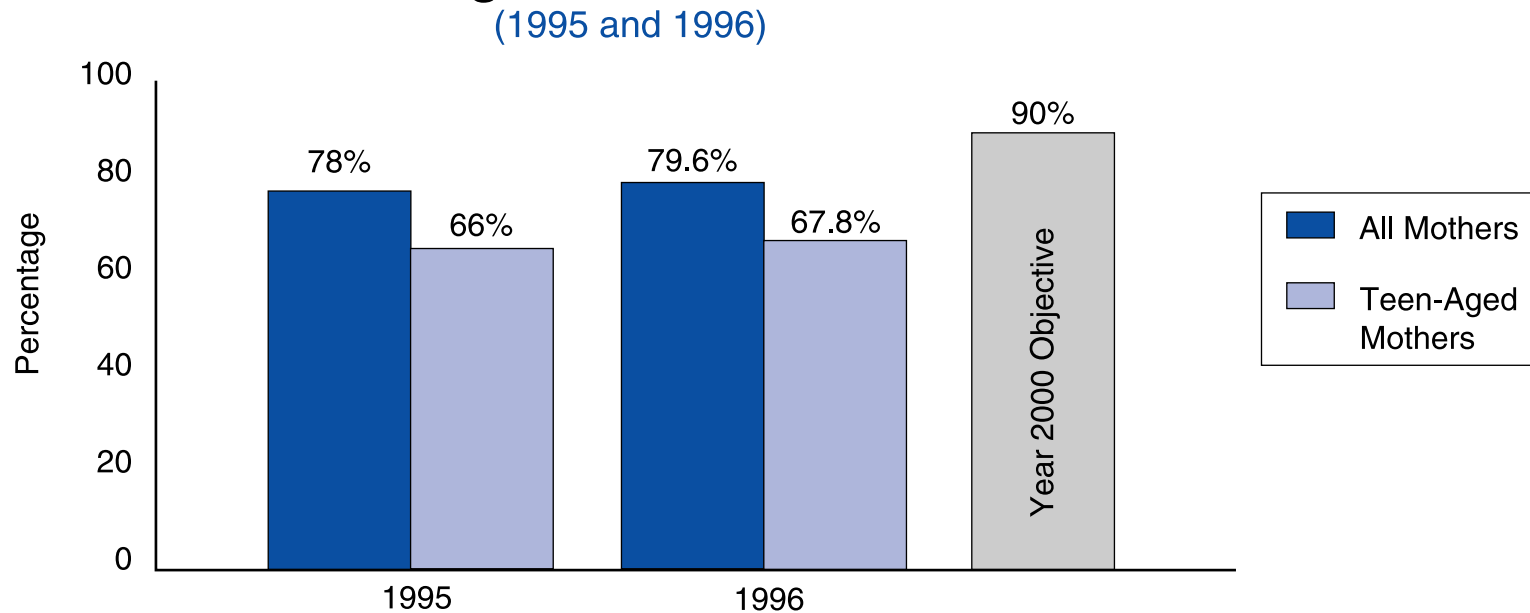
Fortunately, an estimated 95 percent of all California mothers receive prenatal care by the end of the second trimester.

* ***“Year 2000 National Health Objective”*** refers to the *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* designed and established by the federal government as “a national strategy for achieving a healthier population as we approach the year 2000.” The objectives are widely accepted as goals that are worth striving for, so that—with the proper focus and attention—we, as a state and a nation, may be able to improve our collective health.

Mothers Receiving First Trimester Prenatal Care



Mothers Receiving First Trimester Prenatal Care



Births (continued)

In 1996, one out of every sixteen female teenagers between the ages of 15 -19 gave birth in California resulting in 64,616 births, or the equivalent of 63 births per 1,000 female teens. This frequency has been decreasing since 1991 but is still higher than the Year 2000 National Health Objective of 50 births per 1,000* girls.

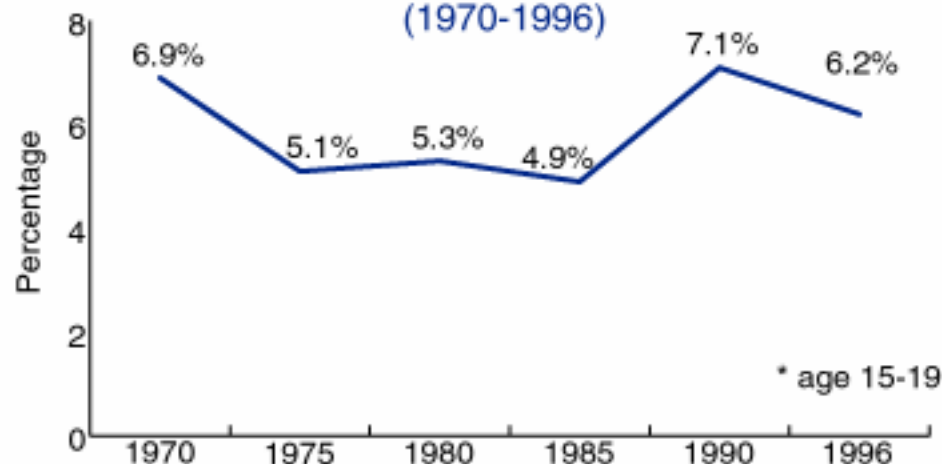
Teen births in California and the United States are significantly higher than in other industrialized countries. In 1996, the California teen birth rate was 63.4 and the U.S. rate was 54.7. Rates in other industrialized countries vary from a low of 4 in Japan (1993) to 26 (1990) in Canada and 31 (1993) in the United Kingdom.

Infants born to teen mothers have significantly higher risk of low birth weight, prematurity, and infant or neonatal death compared to infants of mothers over twenty. Teen mothers are faced with associated problems of continued education and job training, social support, and effective parenting.

* *National Health Objective is for teenage girls age 17 and younger*

Percent of Female Teenagers* Giving Birth

(1970-1996)

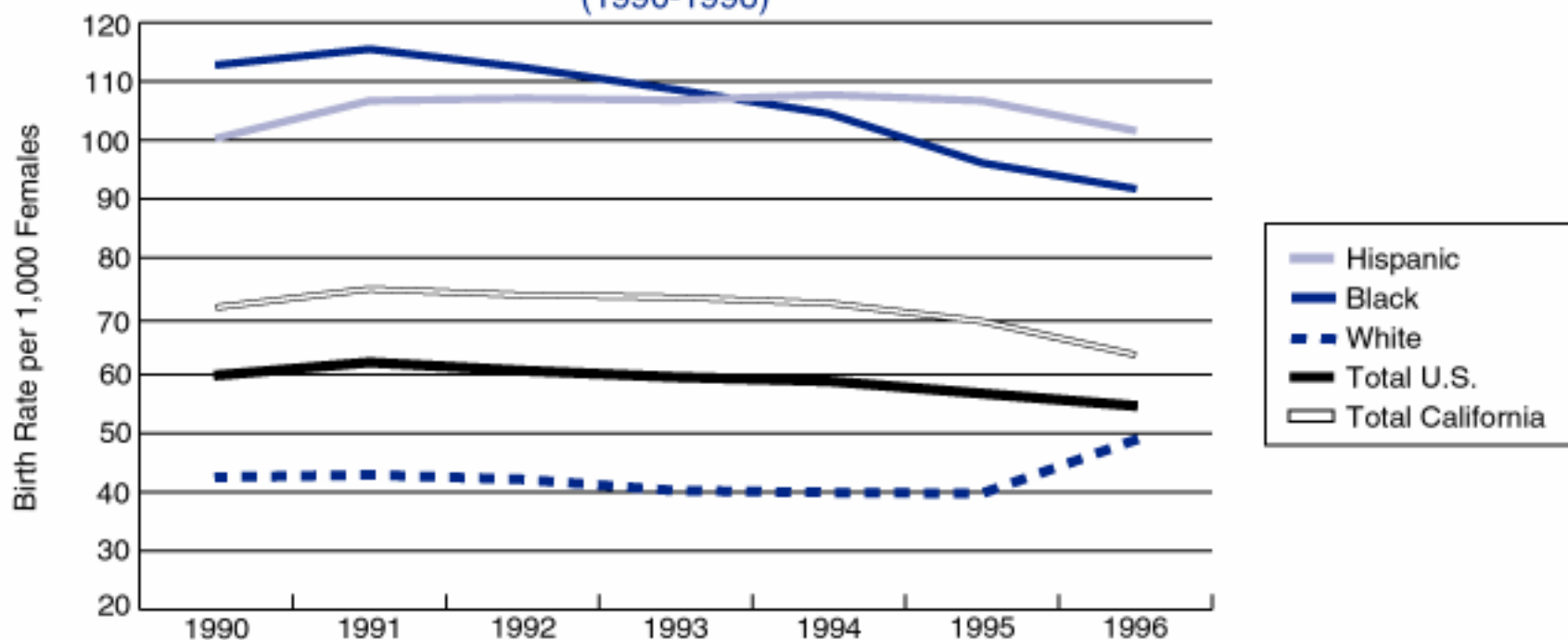


Total Births, Teens, Teen Births (1970-1996)

Year	Number of Total Births	Number of Teen-Aged Girls (15-19)	Number of Teen-Aged Girls (15-19) Giving Birth
1970	362,652	893,834	61,757
1975	317,318	1,031,244	53,397
1980	402,270	1,038,781	55,521
1985	470,816	1,020,601	51,255
1990	611,666	975,466	70,951
1995	551,226	978,492	68,284
1996	538,628	1,019,677	64,616

Teen Births by Ethnicity for United States (age 15-19)

(1990-1996)



Births (continued)

In 1996, cesarean births accounted for 20.6 percent of total births, marking nine years of steady decline in the cesarean birth rate. Despite improvement, the number of cesarean births as a percentage of total births continues to be more than twice what it was in the early 1970s.

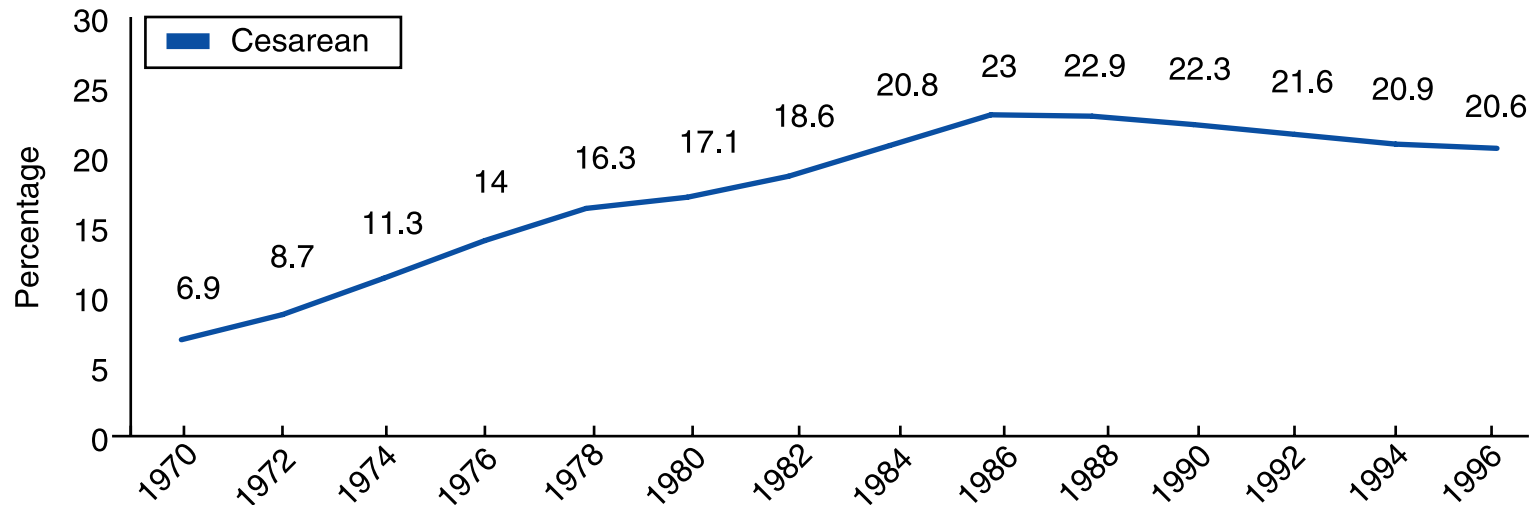
Research has shown that morbidity and mortality risks to both mother and infant are higher for cesarean delivery than for vaginal delivery, even in cases of repeat cesarean deliveries. In the past, cesarean deliveries were performed routinely to reduce risk if a woman had previously given birth by cesarean section. Because of increased risk, longer hospital stays, and higher costs, the U.S. Public Health Service established Year 2000 National Health Objectives which set a goal for the number of cesarean births to equal no more than 15 percent of total births.

The average hospital charge for a cesarean delivery in California is slightly more than twice the charge for a vaginal birth, primarily because the length of stay is about twice as long.

California would need to reduce the number of cesarean births by almost 30,000 (based on 1996 data), or 28 percent, to meet the National Health Objective. The associated reduction in hospital charges would be approximately \$146,000,000. A historical analysis of cesarean birth rates performed by California Department of Health's Center for Health Statistics concluded it would be unlikely that California would meet the Year 2000 Objective.

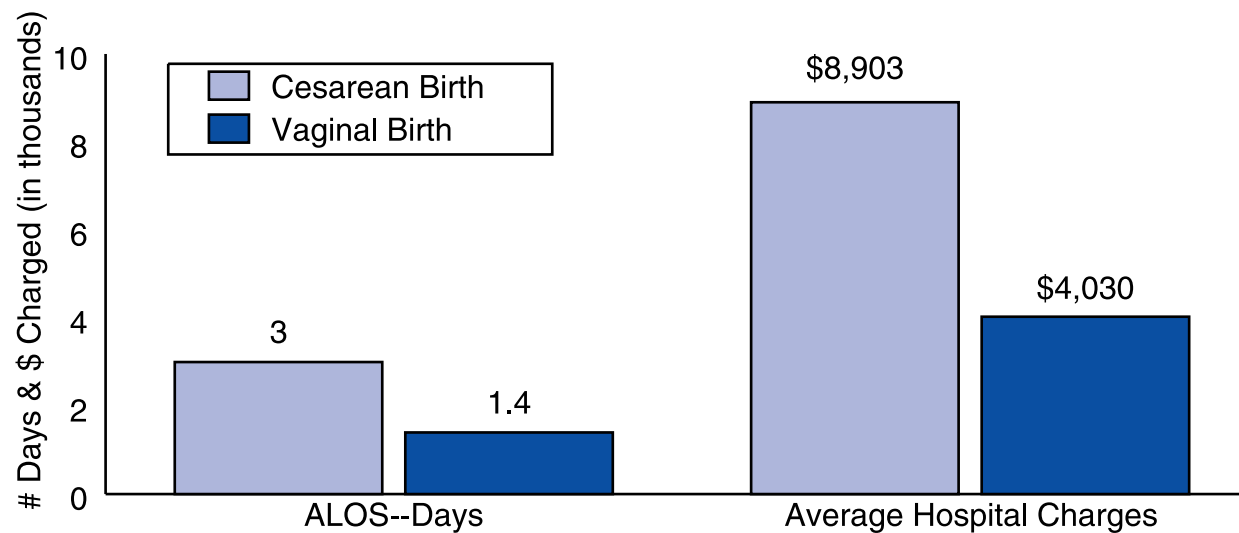
Cesareans as % of All Births

(1970-1996)



Length of Hospital Stay and Charges Cesarean vs. Vaginal Births

(1996)



Immunizations

According to the 1997 Kindergarten Retrospective Study*, the California immunization rate for kindergarten children was about 59 percent at the age of 24 months. Although the State has made significant progress by increasing the number of two year old children that are adequately immunized**, California is still below the nationwide target of a 90 percent immunization rate for two year olds by the year 2000. In an attempt to achieve the 90 percent goal, many state and county coalitions have formed to organize the effort, and some improvement is evident in the last few years.

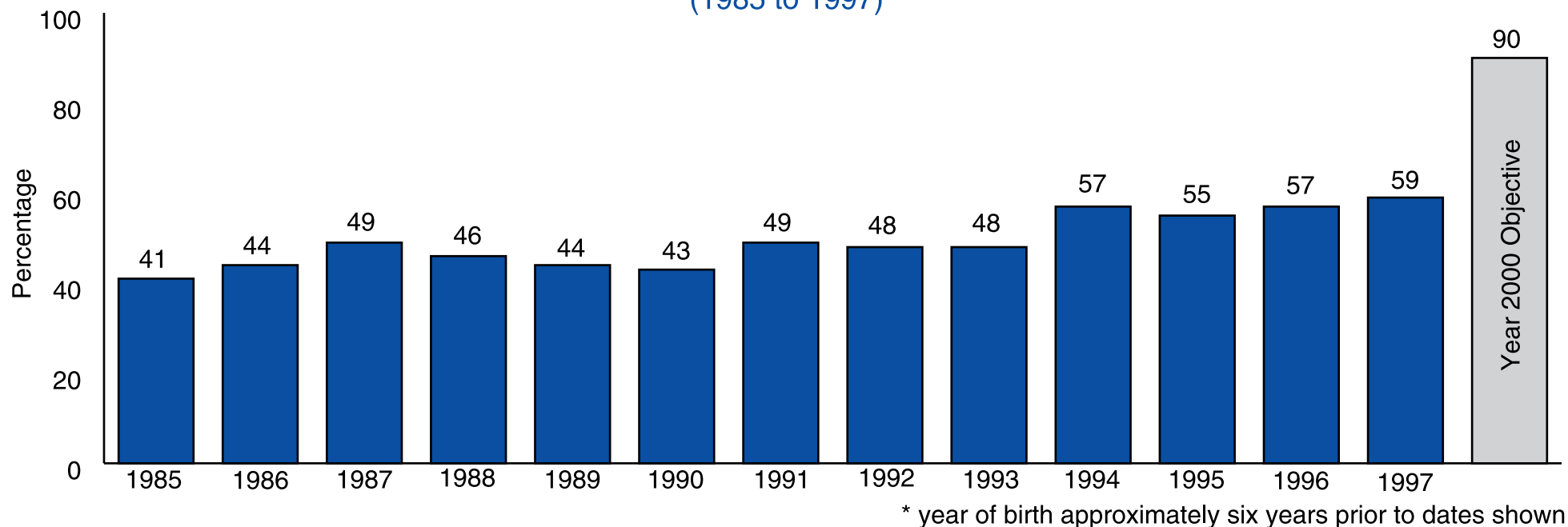
In California, White and Asian children are six to eight percent above the state average for immunizations, but the percentages of adequately immunized Black and Hispanic children remain below average. The lower rates among Blacks and Hispanics may be due to socioeconomic and cultural barriers, or differences in insurance coverage.

**Since 1983, California staff of both the State and local health departments visit a randomly selected sample of approximately 250 schools with kindergartens. At these visits, a sample of children is selected from the enrollment files for a complete review of their on-site immunization records. In 1991, the sample was increased from two children at each site to one for every 15 children enrolled and in 1993 the sample size was again increased to 1 in 8 children. The survey looks at the immunization status of each at various age check-points.*

***A child is considered adequately immunized if, at two years, they have received all four Diphtheria, Tetanus, Pertussis immunizations; three Polio immunizations; and one Measles, Mumps and Rubella immunization.*

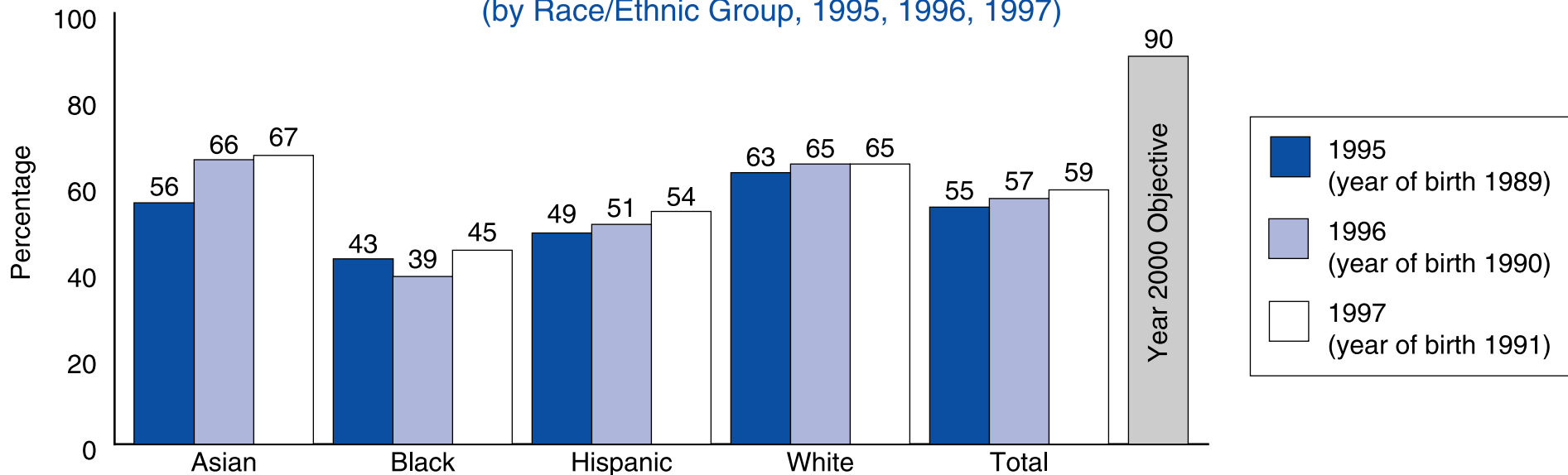
Percent of Children Adequately Immunized at Age Two*

(1985 to 1997)



Percent of Children Adequately Immunized at Age Two

(by Race/Ethnic Group, 1995, 1996, 1997)



Infant Death

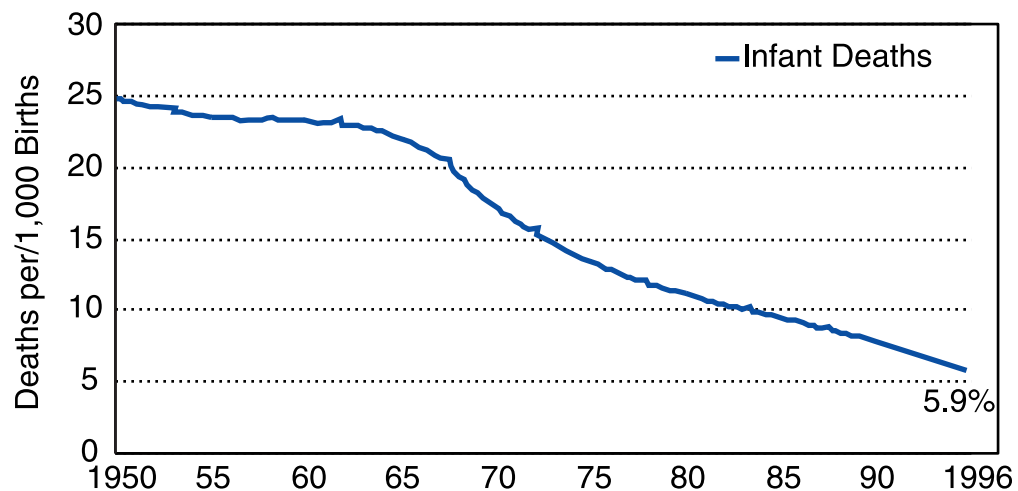
California has consistently had one of the lowest infant death* rates, lower than the national average. The infant death rate in 1996 was the lowest ever recorded, at 5.9 infant deaths per 1,000 live births, down from 6.3 deaths in 1995. The 1996 rate represents a 30 percent decline for California over the past ten years. The national average infant death rate is also declining.

The Year 2000 objectives have successfully been met for three out of four population groups. Blacks continue to have a much higher infant mortality rate than any other racial/ethnic group (14 per 1,000) and have not yet reached the Year 2000 National Health Objective.

**An infant death is defined as a death occurring during the first year of life. Almost half of California's infant deaths are due to premature birth and low birthweight conditions.*

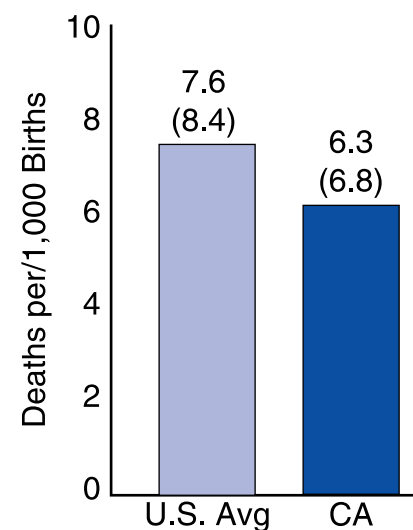
California Infant Death Rates

(1950-1996)



Infant Death Rates: California vs. U.S.

1995 vs 1993



California Infant Death Rates* by Race

(1985-1996)

Year	Asian	Black	Hispanic	White
1985	7.9	15.8	7.9	8.3
1987	8.2	15.3	7.1	7.9
1989	7.7	15.6	7.0	7.4
1991	5.8	13.2	6.2	6.2
1992	5.7	13.9	5.9	6.0
1995	5.7	12.4	5.6	6.0
1996	3.9	14.0	5.4	5.6
Year 2000 Objective	7.0	11.0	7.0	7.0

*Per 1000 births

Deaths of California Children

In 1995, a total of 3,391 Californians from one to 19 years of age died--slightly less than in the previous year (3,528 deaths). Death among adults is generally attributable to disease. Childhood deaths are mostly attributable to injuries, homicide and suicide.

Up until children reach 14 years of age, the most prevalent causes cited for death in boys and girls are motor vehicle and unintentional injuries. In the 15 to 19 year age group, 78 percent of the deaths are male. Homicide is cited as the number one cause of death in this group.

Firearms were a leading cause of all homicide deaths of young Californians. Ninety percent of the victims were male teenagers, most of whom were 15 to 19 years of age.

Injuries related to cars accounted for 22% of deaths of children 15 to 19 years of age.

Suicide was the third leading cause of death in the 15-19 year old age group.

Leading Causes of Death For Young Californians

(1995)

AGE	MALES	FEMALES
1 yr - 4 yrs	<ol style="list-style-type: none"> 1. Unintentional Injuries 39% by Motor Vehicles 32% by Drowning 2. Birth Defects 3. Cancer 30% by Leukemia 	<ol style="list-style-type: none"> 1. Unintentional Injuries 59% by Motor Vehicles 26% by Drowning 2. Birth Defects 3. Cancer 50% by Leukemia
5 yrs - 9 yrs	<ol style="list-style-type: none"> 1. Unintentional Injuries 64% by Motor Vehicles 21% by Drowning 2. Cancer 56% by Leukemia 3. Birth Defects 	<ol style="list-style-type: none"> 1. Unintentional Injuries 60% by Motor Vehicles 2. Cancer 45% by Leukemia 3. Birth Defects
10 yrs - 14 yrs	<ol style="list-style-type: none"> 1. Unintentional Injuries 56% by Motor Vehicles 13% by Firearms 2. Homicide 87% by Firearms 3. Cancer 41% by Leukemia 	<ol style="list-style-type: none"> 1. Unintentional Injuries 70% by Motor Vehicles 3. Cancer 60% by Leukemia 2. Homicide 72% by Firearms
15 yrs - 19 yrs	<ol style="list-style-type: none"> 1. Homicide 90% by Firearms 2. Unintentional Injuries 71% by Motor Vehicle 9% by Drowning 6% by Firearms 3. Suicide 	<ol style="list-style-type: none"> 1. Unintentional Injuries 89% by Motor Vehicle 2. Homicide 83% by Firearms 3. Suicide

Coronary Heart Disease and Stroke - Leading Causes of Death

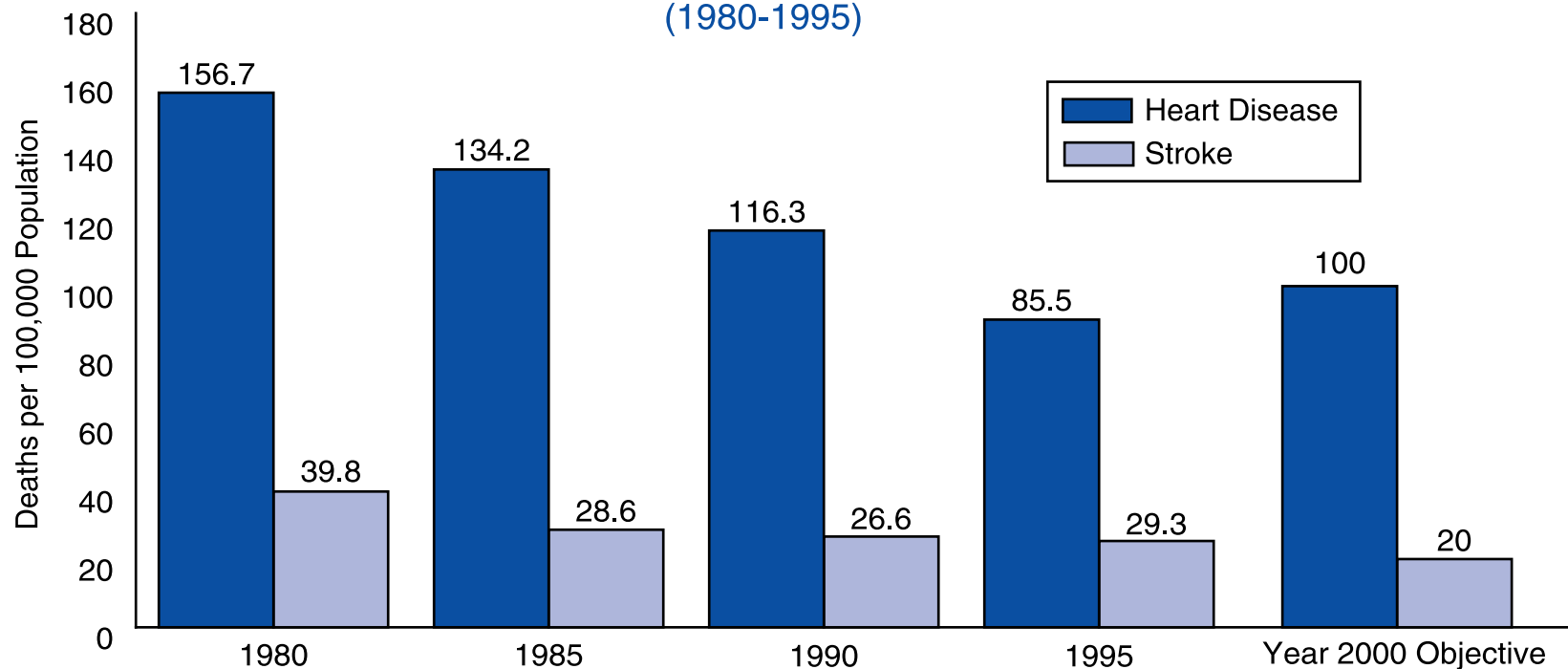
Nearly one fourth of the general population is estimated to have some form of cardiovascular (heart or blood vessel) disease. Hypertension, or high blood pressure, is the most common condition and is a significant risk factor for heart disease and stroke (a blockage or hemorrhage of blood vessels to the brain). Cardiovascular disease has been the leading cause of death in this country every year of this century, except one (1918, the year of the flu epidemic). In 1995, cardiovascular diseases were the cause of nearly 42 percent of all deaths in the United States. More than 2,600 Americans die each day from some form of cardiovascular disease, most often from coronary heart disease (heart attack) and stroke.

The age-adjusted death rate for coronary heart disease peaked in the early 1960s at over 240 deaths per 100,000 and has since declined steadily. In 1995, California achieved a rate of 85.5 deaths per 100,000--well below the Year 2000 National Health Objective of 100. For strokes, the rate in California was 29.3, a significant reduction from the 1980 rate of almost 40 but still above the Year 2000 objective of 20.

Heart disease and stroke, while still among the most prevalent disorders, are preventable. The major risk factors of coronary heart disease and stroke are similar. Personal attention to proper diet, regular exercise, no smoking, and visits to a primary care physician for management of high blood pressure, diabetes, and other risk factors, is necessary.

Death Rates from Coronary Heart Disease* and Stroke**

(1980-1995)

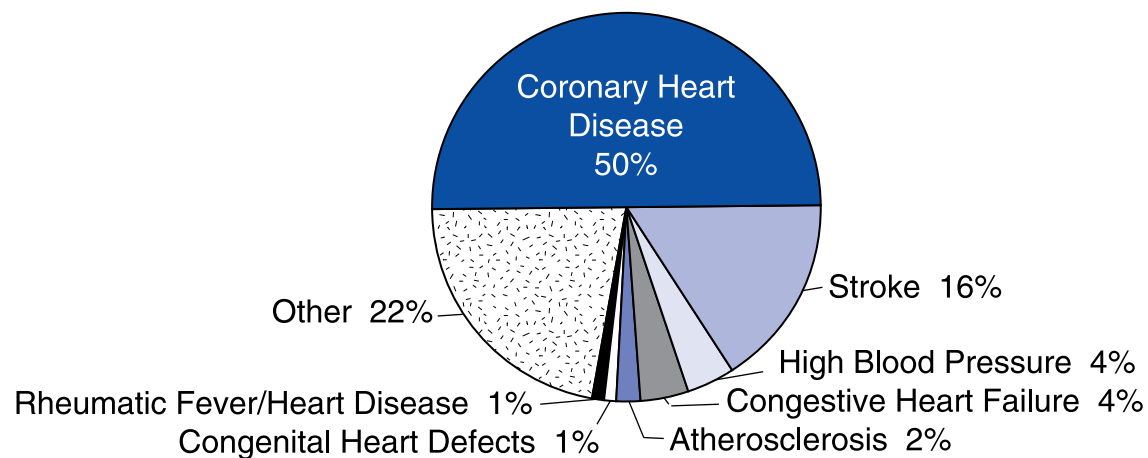


* includes ICD-9 codes 410-414

** includes ICD-9 codes 430-438

Deaths from All Cardiovascular Diseases in United States

1995



Breast and Prostate Cancer

Breast Cancer: Between 1991 and 1995, there were over 90,000 cases of female breast cancer diagnosed in California, more than any other form of cancer among women. During the same time period, over 21,000 women died from the disease. About 50 percent of women diagnosed with breast cancer were 65 years or older, 30 percent were 50-64 years old, and 20 percent were less than 50 years old. The estimated rate is now almost 20,000 new cases of breast cancer a year.

The highest incidence of breast cancer is among White females, followed by Black, Hispanic, and Asian. However, the highest mortality rate is among Black females, followed by White, Hispanic, and Asian. In 1995, incidence rates for Black and Asian females decreased, and mortality rates for White and Hispanic females decreased. The mortality rate for Black females increased slightly.

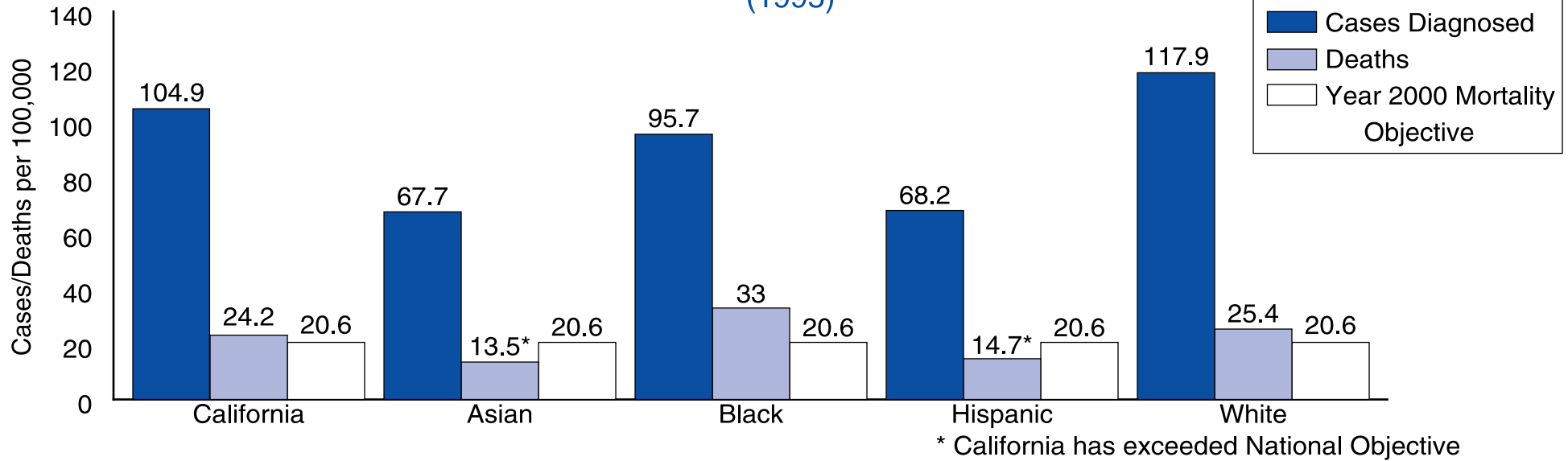
The national five-year survival rate (women living five years after breast cancer is diagnosed) is now 84 percent--up from 72 percent in 1973, as a result of early diagnosis and treatment.

Prostate Cancer: Prostate cancer is the most common form of cancer among men. In 1995, the incidence rate in California was 121.5 cases per 100,000 persons. Nearly 17,000 new cases were diagnosed, of which 80 percent were in men 65 years or older.

In 1995, prostate cancer incidence and mortality rates were highest among Blacks--50 percent higher than the state average for incidence and twice the state average for deaths. Asians had the lowest incidence rates for prostate cancer and mortality rates at half the state average. Nationally, the five-year survival rate for all stages of the disease is 88.5 percent. The five-year survival rate is well above 90 percent for cases diagnosed when the cancer is at the localized or regional stages, but it drops dramatically, to about 30 percent, when it has already progressed to a distant stage.

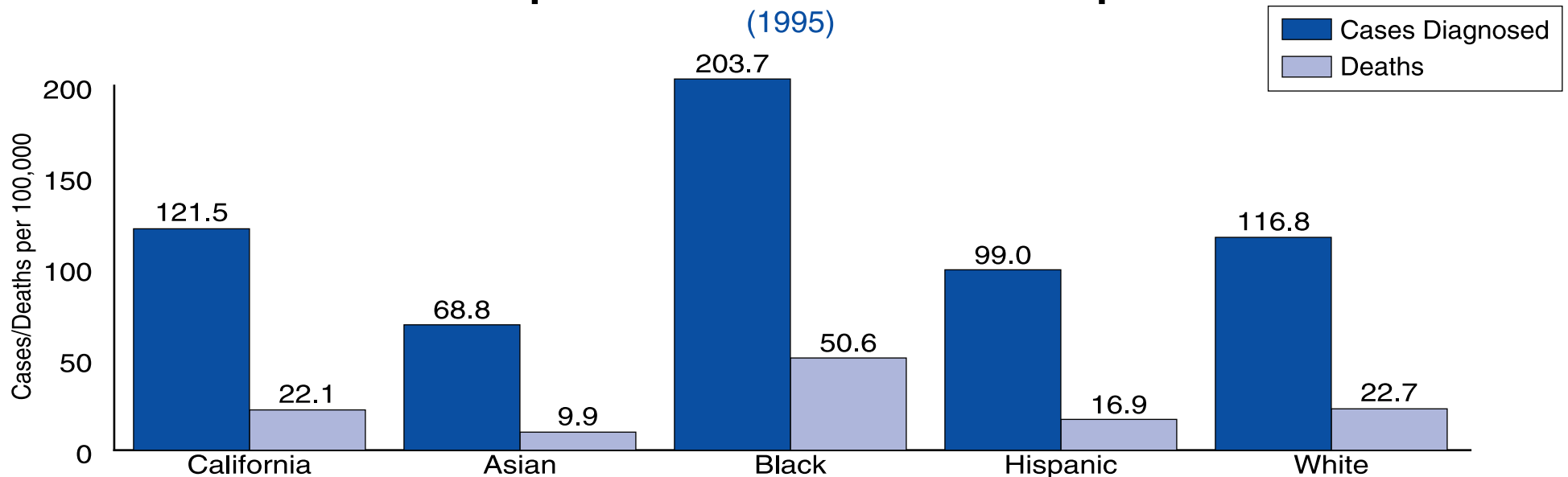
Female Breast Cancer: Cases Diagnosed, Deaths Comparison of Race/Ethnic Groups

(1995)



Prostate Cancer: Cases Diagnosed, Deaths Comparison of Race/Ethnic Groups

(1995)



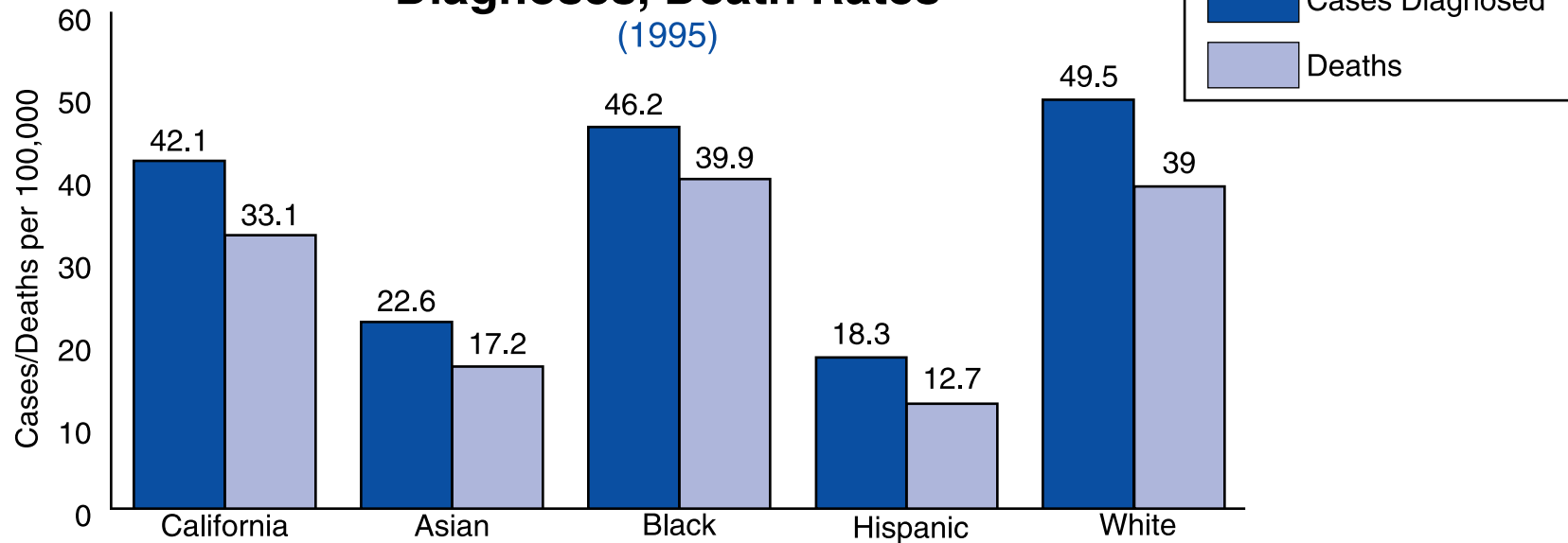
Lung Cancer

Lung cancer is the second most commonly diagnosed cancer and the leading cause of cancer-related deaths among both men and women. In 1995, it accounted for nearly 17,000 new cases and 14,000 deaths in California. Although the lung cancer incidence rate in men decreased by 19 percent between 1988 to 1995, incidence and mortality rates for men remain about 60 percent higher than for women. Over the same period, lung cancer incidence rates among women declined by 7 percent. Nationally, the five-year survival rate for individuals diagnosed with lung cancer is only 15.5 percent.

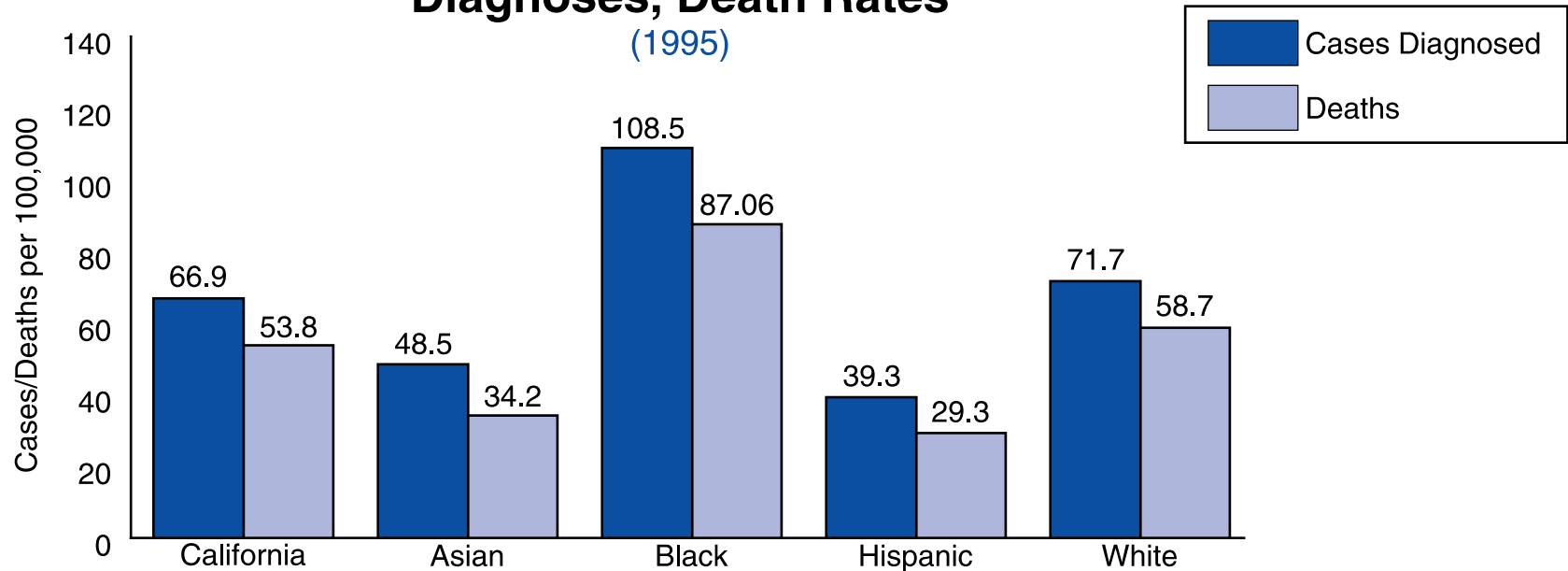
The primary risk factor for lung cancer is smoking. Eighty-five percent of diagnosed lung cancer cases are attributable to cigarette smoking, not including exposure to environmental tobacco smoke. Since 1990, significant declines in the prevalence of adult smokers have taken place. Unfortunately, no observable decline in adolescent smoking has occurred. It is estimated that smoking-related conditions (cancer, cardiovascular diseases, chronic pulmonary diseases, and deaths due to fires) account for 20 percent of all California deaths each year.

The Year 2000 National Health Objectives' goal for deaths from lung cancer is no more than 42 deaths per 100,000 population.

Lung Cancer in Women Diagnoses, Death Rates (1995)



Lung Cancer in Men Diagnoses, Death Rates (1995)



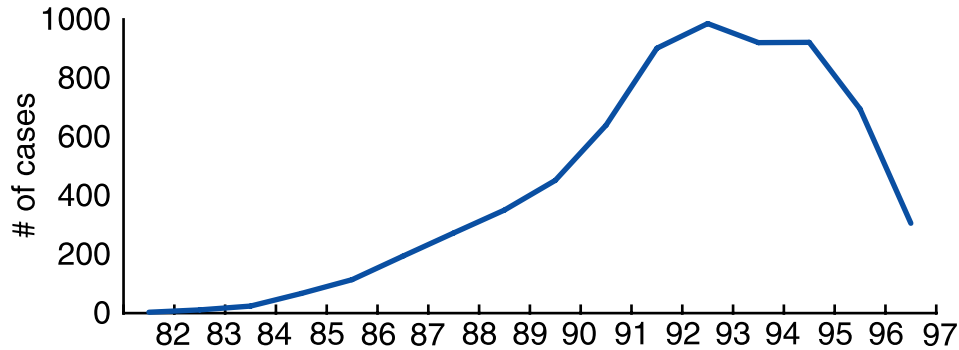
AIDS

Acquired Immunodeficiency Syndrome (AIDS) is the leading cause of death in California for men 25-44 years of age. New cases of AIDS continue to be reported* each year, but at a declining rate. There were 6,341 new cases reported in 1997, compared to 9,264 in 1996 and 9,777 in 1995. By the end of 1995, the total number of reported AIDS cases had reached 89,033 and by the end of 1997, total cases had increased to 104,638 of which 66,263 subsequently died from the disease. California currently accounts for over one sixth of all AIDS cases reported in the United States.

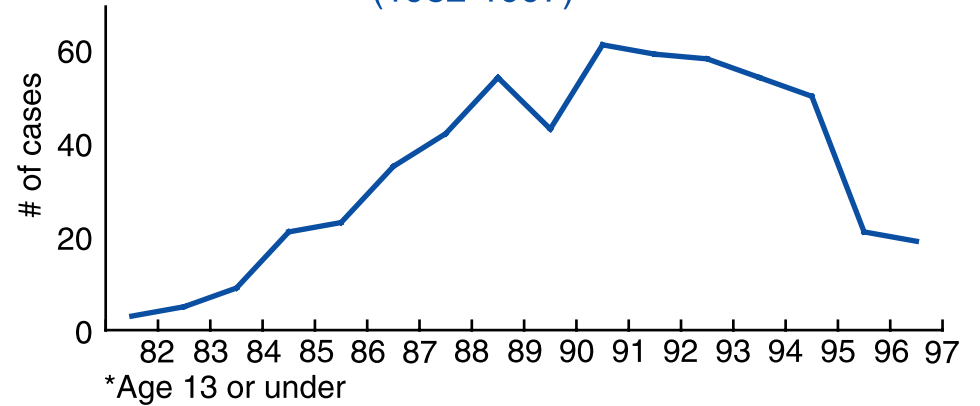
The number of cases reported in 1997 declined in all subgroups when compared to cases reported in 1996. The decline was steepest among whites, and among men having sex with men. Groups showing less of a decline in reported cases included women, minorities, and cases whose mode of transmission was reported as heterosexual contact. Cases among women are still a small percentage of total cases, but women have had a growing proportion of new cases reported each year for the past ten years. Infections among women are due primarily to heterosexual contact (43 percent), followed closely by intravenous drug use (39 percent). Most children diagnosed with AIDS were born to women infected by HIV. The number of infected children has declined over 50 percent in the past two years presumably due to the availability of AZT therapy for infected mothers.

** Many factors affect reportable condition counts. The definition of AIDS was broadened in 1993, resulting in a large increase in new cases initially, followed by a stabilized trend. New treatment medications, introduced in recent years, have resulted in a decline in new cases reported.*

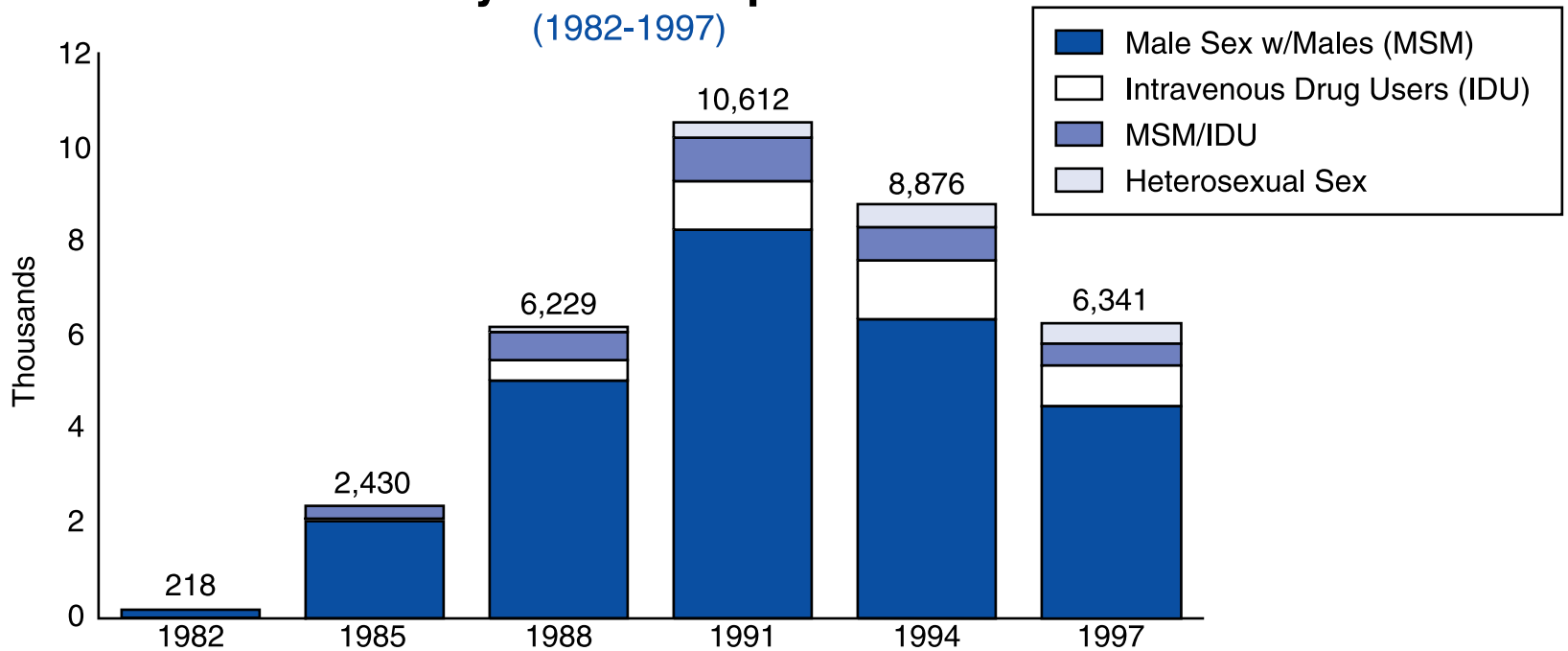
Female AIDS Cases
Diagnosed Per Year
 (1982-1997)



Pediatric* AIDS Cases
Diagnosed Per Year
 (1982-1997)



Diagnosed Cases of AIDS
by Risk Group**
 (1982-1997)



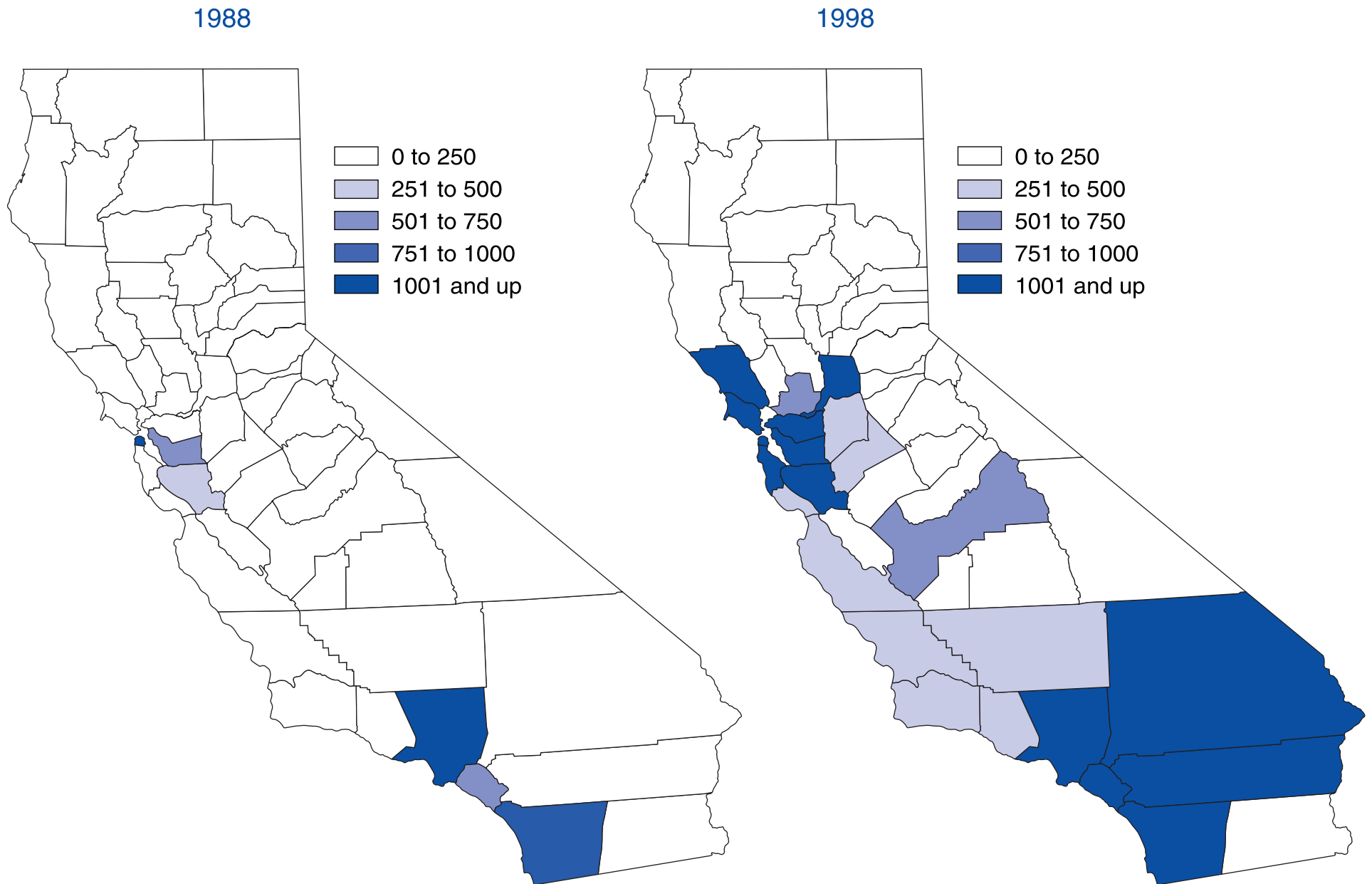
** Data represent the number of cases diagnosed in each specific year (excluding hemophiliacs, transmission through blood transfusion, and other unreported exposure types).

AIDS (continued)

Geographically, San Francisco has the highest AIDS incidence rate per 100,000 population in California with a 1997 rate of 137.2 per 100,000, compared to a statewide rate of 18.8 per 100,000. Marin, Los Angeles, Alameda and Sonoma follow with the next highest rates. Some of the more populated counties in the state have shown a decline in the number of new cases reported in recent years. San Francisco County accounted for 21.6 percent of all cases reported before 1997, but only 16.4 percent of those reported in 1997. The percentage of new cases reported from Los Angeles County declined less dramatically, dropping from 31.8 before 1997 to 30.1 in 1997. Cases reported from the rest of the state increased from 46.6 percent before 1997 to 53.5 percent in 1997.

The Office of AIDS estimates that between 95,000 and 130,000 individuals living in California are currently infected with the Human Immunodeficiency Virus (HIV). HIV infection is not currently reportable in California, except for the advanced stage of the infection which meets the AIDS definition. The availability of new medications has allowed infected individuals to remain healthier longer and delay the onset of AIDS. However, a decline in reported cases does not mean that the epidemic is over. Estimates of new HIV infections in California indicate that over 6,000 new individuals still become infected each year.

Cumulative AIDS Cases by California County



Mental Health

Mental health problems are more prevalent than is generally known. It is estimated that 20 percent or more of the 24 million adults in the State population are affected by some form of mental health problem in any given year. Of these, some ten percent are deemed serious affective disorders, such as manic-depressive, major depression, schizophrenia and paranoid disorders. Total prevalence rates for children and youth are not known, but it is estimated that three to five percent of the 9 million children and youth in California suffer severe emotional or behavioral problems. These rates are reflected in hospital admission figures, noted on page 43, which show psychoses represents the second most common reason for hospitalization in California.

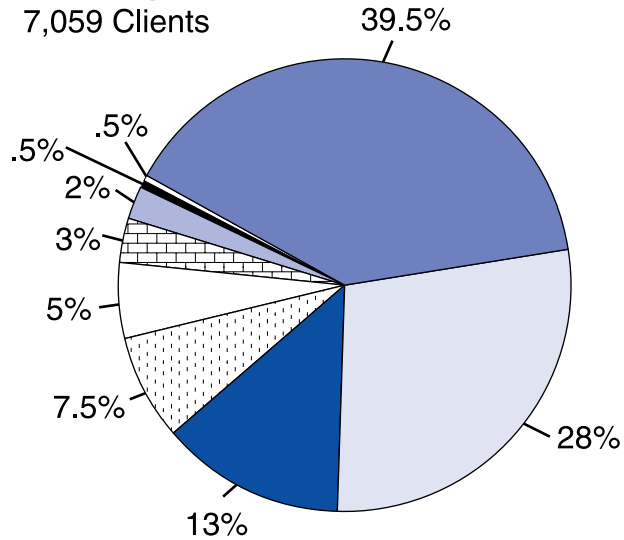
Mental health treatment services are provided in a variety of settings including: community hospitals and clinics, skilled nursing facilities with special treatment programs, county mental health programs in all 58 counties, and four state psychiatric hospitals. Mental health services are provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, and by primary care providers.

The majority of mental health care is successfully managed on an ambulatory basis with appropriate counseling and, when necessary, psychiatric care and medication. Many with serious mental health problems are unable to afford private mental health services, and receive care from publicly-funded county mental health programs. Services available may include hospitalization, skilled nursing or residential care, day treatment, case management, office visits, and clinic care. In Fiscal Year 1995-96, over 7,000 patients were served in state hospitals and nearly 340,000 were treated in county mental health programs.

Persons Served in State Hospitals & County Mental Health Programs By Diagnostic Category (FY 1995-96)

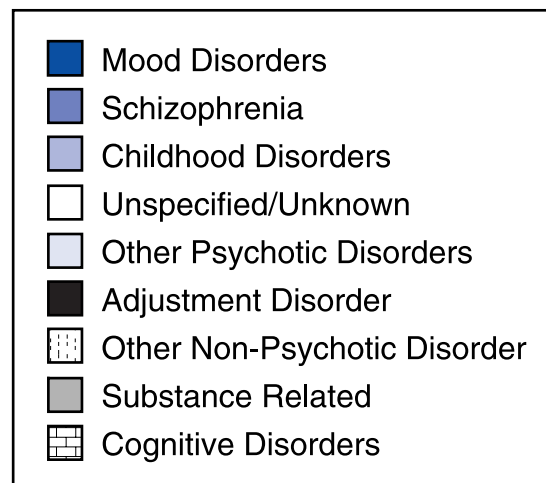
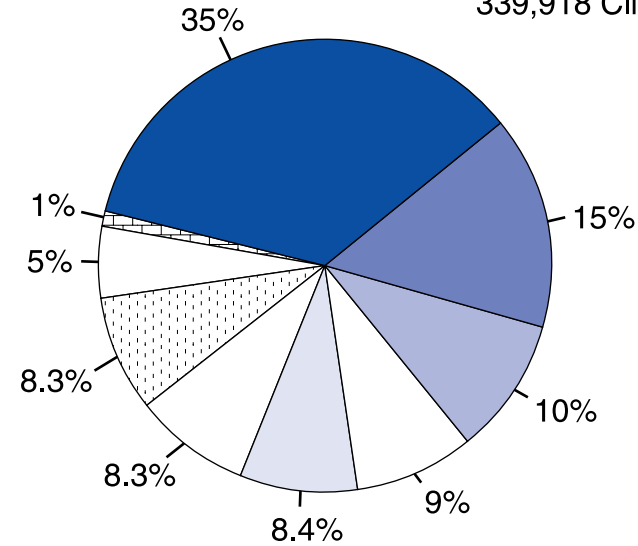
State Hospitals

7,059 Clients



County Programs

339,918 Clients



Alcohol and Drug Abuse

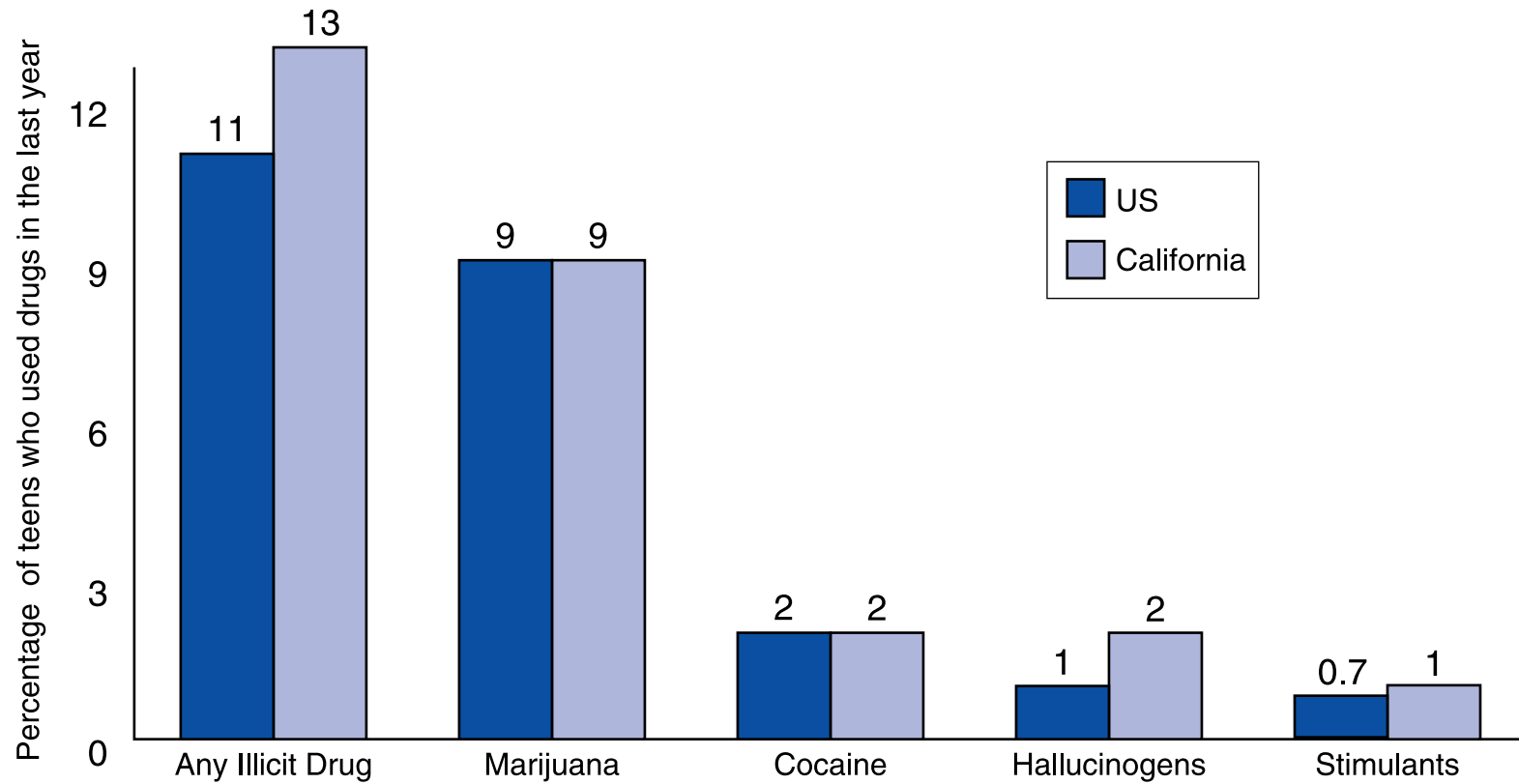
Economic information from the California Department of Alcohol and Drug Programs indicates that over \$19.8 billion per year is lost due to the effects of alcohol and drug abuse. This includes crimes, incarcerations, lost productivity, motor vehicle accidents, social welfare programs, AIDS, and alcohol and drug-affected infants.

Approximately 69,000 infants born in California in 1992 were born to mothers who had used alcohol and/or other drugs during pregnancy. This is 11 percent of all births. Use of alcohol and other drugs during pregnancy can result in physical, developmental, and behavioral problems in the infant. Defects caused by alcohol and drug use are entirely preventable.

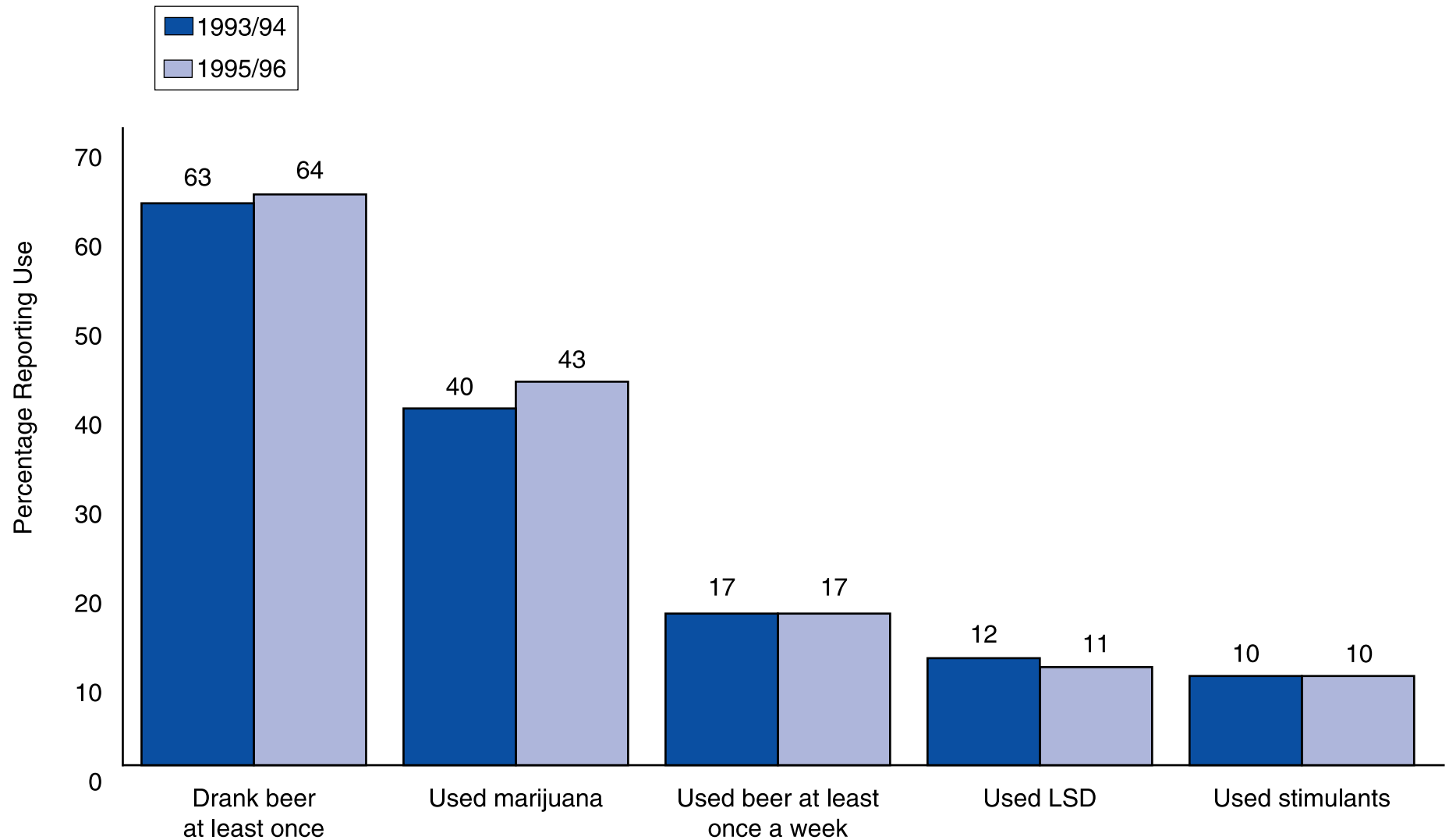
Alcohol and drug use among high school students continues to be significant. In 1993, 10.2 percent of ninth graders reported drinking beer once a week or more, while 17.2 percent of eleventh graders reported drinking beer weekly or more often. Weekly use of marijuana, inhalants and amphetamines was reported by more ninth graders in 1993 than in any of the previous survey years, and between 1987 and 1993, weekly use of marijuana doubled—from 4.3 percent to 9.9 percent.

School attendance problems are often associated with alcohol and drug use. A 1994 study of California students found that those who dropped out of school used drugs and alcohol more frequently than those who remained in school. A survey showed that 79.2 percent of high school dropouts consumed beer, 66.8 percent used marijuana, 31.6 percent used methamphetamines or amphetamines, 27.5 percent used cocaine/crack and 22.6 percent used LSD.

Illicit Drug Use by Teens US and California Comparisons (1994)



Drug Use in Previous Six Months California 11th Grade Students (1993/94 and 1995/96)



Section Five

Challenges for the Future

Challenges for the Future

The information presented in the ***Fact Book*** points to challenges that face Californians as decision-makers and participants in the future of health care. Developing strategies to provide health insurance coverage for the 25 percent of the population that is currently uninsured is important. Efforts already underway to meet this challenge include: increased participation in health insurance pools that currently allow small employers to provide insurance for their employees cost-effectively; expanding publicly financed programs to cover certain sectors of the uninsured, such as children; and the creation of more affordable private pay options for purchasing health insurance. Reaching such a goal depends on continued success with efforts to contain costs throughout all segments of the health care delivery system.

Another challenge is to improve access to primary care and preventive services for all Californians. It is likely that improved access will entail: increasing overall numbers of primary care providers and ensuring that sufficient numbers locate in under-served areas; enhancing cultural competence of providers to better meet the needs of those groups facing language and cultural barriers to care; and increasing health education efforts to underscore the importance of individual and family responsibility for healthy life styles and preventive health care.

An ongoing challenge is to obtain good information about the quality of health services and outcomes of care. Many public sector and health provider based information systems focus on the cost and success of specific treatments or hospitalizations. As competition between providers increases, more emphasis will be placed on the benefits derived from the care received and consumer satisfaction. More complete information about the full range of health care services--for example, ambulatory surgery, emergency room, office visits, as well as hospital care--will be essential to understanding and improving the quality of care provided.

In facing these anticipated challenges, Californians must become increasingly knowledgeable about health care to participate effectively in individual and group decision-making affecting health policy. The information presented in the ***California Health Care Fact Book*** provides a starting point.

Appendix A

Data Sources

Data Sources

Section One California Population

Population Data

Population projections from State of California, Department of Finance, Interim County Population Projections, April 1997; Race/Ethnic Population Estimates: Components of Change by Race, 1990-1996, January 1998 [latest data for these race categories: White (non-Hispanic), Asian and Pacific Islander (non-Hispanic), Black (non-Hispanic), and Native American (non-Hispanic). A separate ethnic category is included for Hispanics]. Asian/Pacific Islander and Native American combined as "other" for some discussions.

Other data from DOF, State Census Data Center including: *1990 Census of Population and Housing, Summary Tape File 1, Complete Tables* and U.S. Department of Commerce, *Characteristics of the Population*, and from Department of Health Services, *California Life Expectancy: Abridged Life Tables, California and Los Angeles County, 1993*.

Section Two Health Care Expenditures and Insurance Coverage

Health Care Expenditures

Health expenditure trends (1984 - 1994) from Lewin-VHI, Inc., *A Report on the State of Health Care in California* prepared for the California Business Roundtable and the Henry J. Kaiser Family Foundation, August 1995. Characteristics of the uninsured in this report based on California subsample of the March 1994 *Current Population Survey*, U.S. Census Bureau merged with spending data.

Estimate of health expenditures in 1994, year 2000 projection, and expenditures by payer from Barents Group, LLC, *Health Insurance Coverage and Health Expenditure Trends in California, New York, and Texas, 1994-2000*, a report prepared for The Henry J. Kaiser Family Foundation, May 31, 1995.

Health Insurance

Persons eligible for Medi-Cal and 1989 to 1996 Trends in Insurance Coverage from California Department of Health, *Managed Care Annual Statistical Report for 1998, and Statistical Summary*. Additional sources for Trends in Insurance Coverage from *Uninsured Children and Percentage of Population Under Age 65*, UCLA Health Policy Research Center Policy Brief, February 1998 and California Department of Corporations (enrollees).

Ten largest health maintenance organizations and number of persons covered by plans from California Department of Corporations, Knox-Keene Health Plan Expenditure Report 1995/96.

Section Three

Health Care Providers

Physicians

Population per physician comparisons from the American Medical Association (AMA), *Physician Characteristics and Distribution in the U.S., 1995/96 edition*. Type of practice from AMA publication cited above, Table D-7 (excludes 9,660 physicians who are inactive or whose address is unknown to the AMA). Gender and age of physicians from AMA publication cited above, Tables C-2 and C-3. U.S. Department of Health and Human Services. Summary Report of the Graduate Medical Education National Advisory Committee, Volume I. DHHS Publication No. (HRA) 81-651. Washington, D.C.: U.S. Government Printing Office, 1981.

Ethnicity of physicians from unpublished survey conducted by the Office of Statewide Health Planning and Development (OSHDP), Primary Care Resources and Community Development Division (PCRCDD), 1993.

Geographic distribution of physicians from OSHPD, PCRCDD, Medical Service Study Area data base, designations as of April, 1996.

Data on physician residency programs from OSHPD survey cited above.

Percent of residents training in primary care for Universities of California from *Changing Medical Directions, Second and Fifth Reports*; for private schools from *California Graduate Medical Education Programs Baseline Data, 1993/94 and 1996/97*, OSHPD, December 1996.

Licensed Health Professionals

Data on licensed health professionals from the California Department of Consumer Affairs based on number of active licenses in July 1997. Some persons holding professional licenses may not be practicing at this time; therefore, the totals shown may not represent actual numbers of professionals in practice.

Hospitals

Beds, services, license type, and ownership from OSHPD, *Annual Utilization Report of Hospitals, Licensed Services and Utilization Profiles*, Report Period January 1, 1996 - December 31, 1996.

Hospital net revenue from OSHPD, *Aggregate Hospital Financial Data Summary*, Report Periods Covering Fiscal Year 1996/97.

Average length of stay, occupancy, and surgical procedures from OSHPD, *Annual Utilization Report* cited above. Volume 2

Reasons for hospitalization from OSHPD, California Hospital Inpatient Discharge Data System, calendar year 1996. Top ten operative procedures count only those procedures reported as the principal procedure for each patient discharge. Same day discharges are counted as one day. Charges exclude discharges with no charge. Kaiser and Shriners hospitals do not report charges.

Teaching hospitals from Council of Teaching Hospitals, Association of American Medical Colleges, 1/98. Designated trauma centers from California Emergency Medical Services Agency, 1998.

Long-term Care Facilities

Long-term care facility data from: *OSHPD Annual Utilization Report of Long-term Care Facilities*, Licensed Services and Utilization Profiles, Report Period: January 1, 1996 - December 31, 1996; *OSHPD Long-Term Care Annual Financial Report 1996/97*.

Home Health Agencies

All home health agency data from OSHPD, *Annual Utilization Report of Home Health Agencies*, Licensed Services and Utilization Profiles, Report Period: January 1, 1995 - December 31, 1995.

Clinics

All clinic data from OSHPD, *Annual Utilization Report of Primary Care and Specialty Care Clinics*, 1996.

Section Four

Health Status Indicators

Birth rates and birth related information from California Department of Health Services (DHS), *Vital Statistics of California*. State of California, Department of Finance, Demographic Research Unit, Actual and Projected Births by County, 1970-2006, with Births by Age of Mother and Age-Specific Birth Rates, October 1997. National birth rates from *Morbidity and Mortality Weekly Report*, 9/97, Centers for Disease Control and Prevention, DHHS, Washington, D.C.

Data on prenatal care from California Department of Health Services Birth Records: *1995 Vital Statistics of California*.

Births to teenage mothers from DHS, Vital Statistics Section, Birth Statistical Master Files. Number of teen girls from California Department of Finance, Demographic Research Unit. International comparisons from Child Trends, Inc., Washington, D.C. National data from National Center for Health Statistics, Department of Health and Human Services.

Cesarean sections as a percentage of all births from OSHPD "Profiles of Hospital Patients, California, 1996". Dept. of Health Services, Center for Health Statistics, Planning and Data Analysis Section, *Cesarean Section Births in California 1980-1992, Year 2000 National Health Objectives Special Report*.

Length of hospital stay and charges for cesarean sections and vaginal births from OSHPD, California Hospital Inpatient Discharge Data, 1996.

Immunization data from Immunization Branch, Department of Health Services-*1996 Kindergarten Retrospective Survey, "Immunization Levels of California Toddlers" and "Immunization Levels of California Toddlers: Race and Age"*

California infant death data from DHS, *Vital Statistics of California, 1995*. Infant Deaths and Mortality Rates by State of Residence, Race of Mother, Birth Weight, and Age at Death: United States, 1995 Period Data, National Center for Health Statistics.

Causes of death for young Californians from DHS, *Vital Statistics of California 1997*.

National data on heart disease from American Heart Association, *Heart Disease and Stroke Facts: 1997 Statistical Supplement*. California death rates from DHS, *Vital Statistics of California 1995*.

Data on incidence and deaths from breast, prostate, and lung cancer from DHS, Cancer Surveillance Section. "*Cancer In California, 1988-1995*", April 1998. Data on five-year survival from National Cancer Institute. *SEER Cancer Statistics Review, 1973-1994*.

Data on AIDS from DHS, Office of AIDS and website <http://www.dhs.cahwnet.gov/aids>. AIDS Surveillance Report, January 1998.

Data on mental health from California Department of Mental Health, Statistics and Data Analysis Section.

All data on alcohol and drug abuse from California Department of Alcohol and Drug Programs, Research and Policy Analysis Branch. Survey of alcohol and drug use referred to is Austin, G. and Horowitz, J., *The 1994 Survey of Alcohol and Other Drug Use, and Other Problem Behaviors Among California Dropouts*. Southwest Regional Laboratory, Los Alamitos, California, 1995. In-school data from Sixth Biennial *California Student Substance Use Survey Grades 7, 9, and 11* (1995/96), Rodney Skager and Gregory Austin, August 26, 1996, <http://caag.state.ca.us/cvpcstats/csspress.htm>.

Appendix B

Health Professional Education Resources

Information on medical schools from American Medical Association, *Graduate Medical Education Directory: 1995-1996*.

Nurse practitioner and physician assistant programs from OSHPD, PCRCDD.

Programs in dentistry and pharmacy, and total health professional training programs from California Department of Education, Health Careers Education Unit, *Programs in Health Careers*, April 1994.

Sources for Additional Information

***An inventory of over 100 data bases collected and maintained by State departments is available from:
<http://www.chipp.cahwnet.gov>***

California Office of Health Information for Policy (OHIP)
818 K Street, Fifth Floor
Sacramento, California 95814
(916) 324-0051

For information on health facility cost and utilization contact:

Office of Statewide Health
Planning and Development
Data Users Support Group
818 K Street, Fifth Floor
Sacramento, California 95814
(916) 322-2814
<http://www.oshpd.cahwnet.gov>

For information on data available from DHS contact:

Department of Health Services
Center for Health Statistics
304 S Street, Third Floor
P.O. Box 942732
Sacramento, California 94234-7320
(916) 445-6355
<http://www.dhs.cahwnet.gov>

For information on alcohol and drug programs contact:

The Resource Center
California Department of Alcohol and Drug Programs
1700 K Street, First Floor
Sacramento, California 95814-4037
(800) 879-2772
(916) 327-3728
(916) 323-0633 Fax

For information on mental health programs contact:

California Department of Mental Health
Statistics and Data Analysis Section
815 S Street
Sacramento, California 95814
(916) 327-9320

Appendix B

Health Professional Education Resources

Health Professional Education Resources

Health professional education programs are available in a wide range of educational settings in California including public secondary schools, regional occupational programs and adult schools; the State's community college and university systems; and private colleges and universities. This section lists some of these resources.

There are nine **medical schools**, five in the University of California system and four in private universities. In addition, there is a School of Osteopathy. Those denoted (**) also have programs to train **Physician Assistants**.

University of California, Davis **
School of Medicine

University of California, San Diego
School of Medicine

University of California, Irvine
College of Medicine

University of California, Los Angeles
School of Medicine

University of California, San Francisco
School of Medicine

Loma Linda University, Loma Linda
School of Medicine

University of Southern California, Los Angeles **
School of Medicine

Stanford University **
School of Medicine

Charles R. Drew University
School of Medicine
Los Angeles

College of Osteopathic Medicine of the Pacific **
Pomona

Health Professional Education Resources (continued)

There are five schools of **Dentistry**, two in the University of California system and three in private universities.

University of California, San Francisco
School of Dentistry

University of California, Los Angeles
School of Dentistry

University of Southern California
School of Dentistry
Los Angeles

Loma Linda University
School of Dentistry

University of the Pacific
School of Dentistry
San Francisco

There are four schools of **Pharmacy**, of which one is in the University of California system.

University of California, San Francisco
School of Pharmacy

University of the Pacific
School of Pharmacy
Stockton

College of Osteopathic Medicine of the Pacific
School of Pharmacy
Pomona

University of Southern California
School of Pharmacy
Los Angeles

Health Professional Education Resources (continued)

There are nursing programs in 81 of the State's community colleges and on 19 other campuses which include California State University (CSU), the University of California, and private educational institutions. Students graduating from these programs may be licensed as Licensed Vocational Nurses (LVNs) or Registered Nurses (RNs). Additional education and training can be obtained in a number of settings including the following programs which train ***Nurse Practitioners***.

CSU Fresno
Graduate Nursing Department

Harbor-UCLA
Adult Nurse Practitioner Program
Torrance

CSU Long Beach
Nursing Department

Kaiser Permanente Southern California/
CSU Los Angeles
Joint Nurse Practitioner Program

CSU Los Angeles
Nurse Practitioner Program

Loma Linda University
Graduate School of Nursing
Loma Linda

Education Program Associates/ CSU San Jose
Nurse Practitioner Program

Planned Parenthood of Central California
Nurse Practitioner Program
Fresno

Harbor-UCLA Women's Health Care
Nurse Practitioner Program
Torrance

Foothill College/Stanford University Medical Center
Primary Care Associate/ Family Nurse Practitioner
Program
Palo Alto

Health Professional Education Resources (continued)

Samuel Merritt College
Graduate Nursing Program
Oakland

CSU San Jose
School of Nursing

CSU Sonoma
Nurse Practitioner Program

UC Los Angeles
School of Nursing Graduate Studies

UC Davis
Family Nurse Practitioner Program

UC San Francisco
School of Nursing, Graduate Studies

University of San Diego
Philip Y. Hahn School of Graduate Nursing

University of San Francisco
Graduate School of Nursing

University of Southern California
Graduate School of Nursing
Los Angeles

CSU San Diego
Division of Nursing Education

California Health Policy and Data Advisory Commission

Clark E. Kerr, Chairman — Danville
Representing Business Health Coalitions

Norma Bordelon — Woodland Hills
General Member

Vito J. Genna — Chula Vista
Representing Long-term Care Facilities

Jerry Royer, M.D., MBA — Sacramento
Representing Hospitals

William A. Waite — San Diego
Representing Health Insurance Industry

Maurice J. Alfaro, M.D. — San Diego
Representing Group Prepayment Health
Services Plans

Howard L. Harris, Ph.D. — Sacramento
General Member

Peter Farley, M.D., MBA — San Mateo
Representing Physicians and Surgeons

Pamela K. Kallsen — Fresno
General Member

Hugo Morris — Los Angeles
Representing Labor Health Coalitions

Corinne Sanchez — Panorama City
General Member

Jacquelyn Paige, Executive Director
1600 Ninth Street, Room 432
Sacramento, California 95814
(916) 654-1817

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Letter of Introduction from OSHPD Director David Werdegar, MD, MPH

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, Governor

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

OFFICE OF THE DIRECTOR

1600 9th Street, Room 433

Sacramento, California 95814

(916) 654-1606 FAX (916) 653-1448



Dear Colleague:

We are very pleased to send you the second edition of the California Health Care Fact Book, a special publication produced by the Office of Statewide Health Planning and Development with support from the Robert Wood Johnson Foundation.

The result of a collaborative effort of several State departments and outside organizations, the Fact Book presents an overview of the State's \$100 billion health care industry. The book contains summary data on the health of Californians, the State's health care resources and expenditures for health services. The purpose of this publication is to provide a background of information for considering health policy issues facing California.

Publication of the California Health Care Fact Book will be an ongoing effort of the Office. Therefore, any comments you have would be helpful in preparing future editions and would be greatly appreciated. Please send your suggestions to the attention of "Public Affairs/Fact Book," Office of Statewide Health Planning and Development, 1600 9th Street, Room 435, Sacramento, CA 95814.

We trust you will find this California Health Care Fact Book a useful reference.

Sincerely,

David Werdegar, MD, MPH
Director

*Planning for
California's Health Care Future*

OSHDP

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT